

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05229

5254

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 15 das.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center National Institutes of Health, Bethesda				d. STREET ADDRESS 103 North Van Buren Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Battaile Last Allnutt				4. DATE OF DEATH Month May Day 2 Year 19 56					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 26 April 1887			
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 0 Days 6 Hours Min. 		IF UNDER 24 HRS. 					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY (Retired)		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Henry C. Allnutt				14. MOTHER'S MAIDEN NAME Josephine Viers					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Not available		17. INFORMANT The Medical Record, Clinical Center, NIH Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure 190X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Melanoma to the Liver DUE TO (c) 								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from April 17, 1956 , to May 2, 1956 , that I last saw the deceased alive on May 2, 1956 , and that death occurred at 10, 25 P.M. , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state)				DATE SIGNED					
ACTUAL SIGNATURE J. L. Fahey M.D.				The Clinical Center					
PHYSICIAN'S NAME (Type) John L. Fahey, M.D.				National Institutes of Health					
Bethesda, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/5/1956		22c. NAME OF CEMETERY OR CREMATORY Rockville Union		22d. LOCATION (City, town, or county) (State) Rockville Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.				ADDRESS		24a. REC'D BY REGISTRAR 5-7-56			
				24b. REGISTRAR'S SIGNATURE Bernie M. Thompson					

CERTIFICATE OF DEATH

RECEIVED
MAY 9 1956
BUREAU Y. I.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Medical Examiner (Dr. Blossport) notified & he - O.K. & my issuing this certificate for

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5232

CERTIFICATE OF DEATH

05230

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK	
c. LENGTH OF STAY IN 1b 1 MONTH			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7620 MAPLE AVENUE		d. STREET ADDRESS 7620 MAPLE AVENUE	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES GARNET GORDON BAILEY		4. DATE OF DEATH Month Day Year MAY 27 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 4, 1890
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK, GOV'T. ACCOUNTING OFFICE, U.S. GOV'T.		10b. KIND OF BUSINESS OR INDUSTRY T. HAYS, KANSAS	
11. BIRTHPLACE (State or foreign country) KANSAS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALFRED D. BAILEY		14. MOTHER'S MAIDEN NAME MARY GORDON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW #1		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. WALTER B. HARGETT, 4325 Claggett Rd. University Park, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Sudden 16 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 21, 1940 , to May 27, 1956 , that I last saw the deceased alive on Apr. 10, 1956 , and that death occurred at 5:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9241 Col. Blvd. DATE SIGNED 5/27/56 ACTUAL SIGNATURE J. Marion Bankhead M.D. PHYSICIAN'S NAME (Type) J. Marion Bankhead, Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/29/56	
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey		24a. REC'D BY REGISTRAR 5/29/56	
ADDRESS SILVER SPRING, MARYLAND		24b. REGISTRAR'S SIGNATURE J. Marion Bankhead	

CERTIFICATE OF DEATH

<p>1. Name of Deceased</p>		<p>2. Sex</p>		<p>3. Race</p>	
<p>4. Date of Birth</p>		<p>5. Date of Death</p>		<p>6. Place of Birth</p>	
<p>7. Cause of Death</p>		<p>8. Manner of Death</p>		<p>9. Signature of Physician</p>	
<p>10. Signature of Registrar</p>		<p>11. Signature of Coroner</p>		<p>12. Signature of Medical Examiner</p>	

RECEIVED
MAY 31 1956
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 216

5255

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u> Chevy Chase </u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>1 Quincy Street</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>NANNIE Bell BAILEY</u>				4. DATE OF DEATH Month Day Year <u>5 - 26 1956</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27 1897</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Major Marshall</u>				14. MOTHER'S MAIDEN NAME <u>LAURA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Susie Bailey (Daughter)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>6 hours</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 25 1956</u> to <u>May 25 1956</u> , that I last saw the deceased alive on <u>May 25 1956</u> , and that death occurred at <u>4 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George Sharpe</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>10644 Connecticut Ave 5-26-56</u>			
PHYSICIAN'S NAME (Type) <u>George Sharpe</u>				<u>Kensington, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/1/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat.</u>		22d. LOCATION (City, town, or county) (State) <u>Fort Myer Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Ernest Jarvis Co.</u>				ADDRESS <u>1432 You St. NW</u>		24a. REC'D BY REGISTRAR DATE <u>6/7/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

MEDICAL CERTIFICATION

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J. Pharm. Med.

ROBERT V. S.

9561

1

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5256 CERTIFICATE OF DEATH

05232

Reg. Dist. No.

215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. District of Columbia COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 31 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) The Clinical Center				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Susie Middle Elmira Last Baylis				4. DATE OF DEATH Month May Day 10 , Year 1956			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 13, 1897	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Household duties		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Gillison Wanser				14. MOTHER'S MAIDEN NAME Annie Gaskins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myasthenia Gravis 195X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Neoplasm of thyroid gland DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 9, 1956 to May 10, 1956 , that I last saw the deceased alive on May 10, 1956 , and that death occurred at 5 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Glenn A. Drager M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED May 10, 1956			
PHYSICIAN'S NAME (Type) Glenn A. Drager,				The National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 5/12/56		22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ordew Funeral Home				24a. REC'D BY REGISTRAR DATE 5/16/56		24b. REGISTRAR'S SIGNATURE Mary Gennelly	

BUREAU V. S.

MAY 16 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05233

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

214

5257

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) McCENEY AVENUE, BURNT MILLS HILLS				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS McCENEY AVENUE, BURNT MILLS HILLS e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
3. NAME OF DECEASED (Type or print) First PAUL Middle VERNON Last BETTERS				4. DATE OF DEATH Month MAY Day 12 Year 19 56			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/19/06	
9. AGE (In years last birthday) 50 yrs.		10. UNDER 1 YEAR Months 5 Days 12		11. UNDER 24 HRS. Hours 12 Min. 19			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive Vice-Pres. U.S. Conference of Mayors				10b. KIND OF BUSINESS OR INDUSTRY MORRIS, MINNESOTA		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME BURT BETTERS				14. MOTHER'S MAIDEN NAME OLIVIA CHRISTENSEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW #2				16. SOCIAL SECURITY NO. WW #2			
17. INFORMANT MRS. MYRA K. BETTERS, McCeney Ave.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sudden DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschait M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. Broschait				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 5/12/56		22c. NAME OF CEMETERY OR CREMATORY PT. LINCOLN CREMATORY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey ADDRESS SILVER SPRING, MD.				24a. REC'D BY REGISTRAR 5/15/56		24b. REGISTRAR'S SIGNATURE James Potter	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. file pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
MAY 18 1956
BUREAU V. S.

MAY 18 1956

5258

CERTIFICATE OF DEATH

Reg. Dist. No.

05234

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Alabama b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sumiton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda, Md.		d. STREET ADDRESS none	
3. NAME OF DECEASED (Type or print) First Myrna Middle Loy Last Blackston		4. DATE OF DEATH Month May Day 7 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1955
9. AGE (In years last birthday) yrs. 10 Months 21 Days 21 Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child	
10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Alabama	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jesse Blackston	
14. MOTHER'S MAIDEN NAME Leota Hagood		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. none		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congenital Heart Disease - Tetralogy of Fallot DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia secondary to decreased iron intake - food.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Birmingham		(County) (State)	
21. I certify that I attended the deceased from May 6, 19 56 to May 7, 19 56 , that I last saw the deceased alive on May 7, 19 56 , and that death occurred at 12:50P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Edward H Sharp		M.D. The Clinical Center	
PHYSICIAN'S NAME (Type) Edward H. Sharp, M.D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 5/8/56	22c. NAME OF CEMETERY OR CREMATORY Carbon Hill	22d. LOCATION (City, town, or county) (State) Birmingham, Alabama
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR 2901 14th St., N.W. Washington 9, D.C.	24b. REGISTRAR'S SIGNATURE Bev M. Thompson

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5259

CERTIFICATE OF DEATH

05235 2 14
 Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE MD. b. COUNTY MONTG.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8901 Brookeville Rd		d. STREET ADDRESS 8901 BROOKEVILLE Rd.	
3. NAME OF DECEASED (Type or print) FANNIE FRANCES BRADLEY		4. DATE OF DEATH MAY 4 1956	
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 14 1879
9. AGE (In years last birthday) 76 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Prince William Co. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Fisher		14. MOTHER'S MAIDEN NAME Ellen Hanes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Ms. Gladys Thomas	
17. INFORMANT same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uræmia DUE TO Hypertensive Cardio Renal Disease with Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio Renal Disease with Edema (c) Disease with Edema		INTERVAL BETWEEN ONSET AND DEATH 14 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 12		20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 12 1948 to May 4 1956 , that I last saw the deceased alive on May 3 1956 , and that death occurred at 10:47 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Webster Sewell		ADDRESS (Street, city or town, state) Norbeck Rd 1 Silver Spring Md.	
PHYSICIAN'S NAME (Type) WEBSTER SEWELL		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) 5-9-56		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Church Cemetery		22d. LOCATION (City, town, or county) (State) Silver Spring Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Nancy Washington		ADDRESS 467 N st N. W	
24a. REC'D BY REGISTRAR DATE 5-10-56		24b. REGISTRAR'S SIGNATURE Frances Patterson	

U. S. DEPARTMENT OF JUSTICE

MAY 17 1964

RECEIVED
MAY 17 1964

5260 CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 28 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Maurice Bready				4. DATE OF DEATH May 2 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/18/67	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming-Owner	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Bready				14. MOTHER'S MAIDEN NAME Katherine Baer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Record			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Normie DUE TO Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. nephritis (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) L						INTERVAL BETWEEN ONSET AND DEATH 4/25/56 years days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) L			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. L 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify <input checked="" type="checkbox"/> attended the deceased from 4/1/56 , 19 56 , to 5/2/56 , 19 56 that I last saw the deceased alive on 5/1/56 , 19 56 , and that death occurred at 10:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sandoff DATE SIGNED 5/3/56							
ACTUAL SIGNATURE J. W. Bird M.D.				PHYSICIAN'S NAME (Type) J. W. Bird, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-5-56		22c. NAME OF CEMETERY OR CREMATORY Rockville Union		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR 5-4-56		24b. REGISTRAR'S SIGNATURE Bertine B. Lawler	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1006

1006

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5261

CERTIFICATE OF DEATH

05237

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Urban</u>		d. STREET ADDRESS <u>4827 Leland St.</u>	
3. NAME OF DECEASED (Type or print) <u>John Alexander Brightwell</u>		4. DATE OF DEATH <u>MAY 11 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 21, 1884</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Enterprise</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Brightwell</u>		14. MOTHER'S MAIDEN NAME <u>Matilda McCormick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Un-known</u>	
17. INFORMANT <u>Elizabeth Schaefer</u>		Address <u>4827 Leland St. Chevy Chase, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE 5-11</u> , 19 <u>56</u> , to <u>5-11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-11</u> , 19 <u>56</u> , and that death occurred at <u>6:25 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>P. P. Andrews</u>		ADDRESS (Street, city or town, state) <u>4201 Essenden St. N. W. Washington, D. C.</u>	
DATE SIGNED <u>5-11-56</u>			
PHYSICIAN'S NAME (Type) <u>P. P. ANDREWS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-14-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Funeral Home Bethesda Md.</u>	
24a. REC'D BY REGISTRAR <u>5-11-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 of this certificate may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUAN V. S.

1950



BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05238
5262
CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 1 week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County Gen. Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Samuel V. Broadhurst		4. DATE OF DEATH Month May Day 21 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1866
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operated threshing machines		10b. KIND OF BUSINESS OR INDUSTRY Penn.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George A. Broadhurst		14. MOTHER'S MAIDEN NAME Eliza Snowden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Cramwell King, Gaithersburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO with congestive heart failure + Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) hypertension DUE TO (c) Coronary Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 20 yrs. 10 yrs. 50 yrs. 118 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) The accident	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 7, 1953 to May 21, 1956 , that I last saw the deceased alive on May 20, 1956 , and that death occurred at 7:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Damascus, Maryland DATE SIGNED 5/24/56			
ACTUAL SIGNATURE M. McKendree Boyer, M.D.		DATE SIGNED 5/24/56	
PHYSICIAN'S NAME (Type) M. McKendree Boyer, M.D.		ADDRESS Damascus, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 23, 1956	
22c. NAME OF CEMETERY OR CREMATORY Bethesda		22d. LOCATION (City, town, or county) (State) Brownsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Moleworth		ADDRESS Damascus, Md.	
24a. REC'D BY REGISTRAR DATE 5-23-56		24b. REGISTRAR'S SIGNATURE Bertine B. Lawler	

BUREAU V. S.

1967

RECEIVED

5263

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park	
c. LENGTH OF STAY in 1b 44 days		d. STREET ADDRESS 9616 51st Place	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anthony Middle William Last Brown		4. DATE OF DEATH Month May Day 16 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 23, 1953
9. AGE (In years last birthday) yrs 2		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Brown		14. MOTHER'S MAIDEN NAME Sarah Moss	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) brain abscess 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) acute leukemia DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 2 , 19 56 , to May 16 , 19 56 , that I last saw the deceased alive on May 16 , 19 56 , and that death occurred at 12:00 M, from the causes and on the date stated above ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED May 16, 1956 ACTUAL SIGNATURE Lehran Goulian M.D. National Institutes of Health PHYSICIAN'S NAME (Type) Lehran Goulian, M.D. Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/17/56	22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial	22d. LOCATION (City, town, or county) (State) Spartanburg, S.C.
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co., Silverdale, Md.		24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These permits remain carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 1 1900

RECEIVED

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5264

CERTIFICATE OF DEATH

05240

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt #1 Clarksburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Clinical Center, NIH</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>James Walter Cabell</u>				4. DATE OF DEATH Month <u>5</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 15, 1946</u>	9. AGE (In years last birthday) <u>9</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Cabell</u>				14. MOTHER'S MAIDEN NAME <u>MATTIE L Smith.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Naso pharynx & extension to Left Maxilla & obstruction of nares & production of sinus obstruction & frontal lobe abscess</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>55</u> , to <u>May</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-19</u> , 19 <u>56</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>K. Lemore Yelding</u> M.D.				ADDRESS (Street, city or town, State) <u>National Institutes of Health</u> DATE SIGNED <u>5-19-56</u>			
PHYSICIAN'S NAME (Type) <u>K. Lemore Yelding Bethesda Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>22 May 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Upperville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Upperville, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. L. Burdette, Hyattstown, Maryland</u>				24a. REC'D BY REGISTRAR <u>5/23/56</u>		24b. REGISTRAR'S SIGNATURE <u>Beauregard Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 20 1913

RECEIVED

5265

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR and give nearest town) Westmoreland Hills (in this place)
 TOWN Westmoreland Hills
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 5192 Albemarle St.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Montgomery
 CITY (If outside corporate limits, write RURAL and give nearest town) Westmoreland Hills
 TOWN Westmoreland Hills
 STREET ADDRESS (If rural give location) 5192 Albemarle St.

3. NAME OF DECEASED:

(First) (Middle) (Last) BERNARD ALBERT CHANDLER DATE (Month) (Day) (Year) MAY 28, 1956

5. SEX:

M

6. COLOR OR RACE:

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Married

8. DATE OF BIRTH:

Dec. 20-1884

9. AGE last birthday:

71 yrs.

10. UNDER 1 YEAR: 11. UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done or of working life, if retired):

Retired Engineer

10b. KIND OF BUSINESS OR INDUSTRY:

Internal Rev. Bus.

11. BIRTHPLACE (State or foreign country):

New Gloucester, Maine U.S.A.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Andrew C. Chandler

14. MOTHER'S MAIDEN NAME:

Rosa E. Bean

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY No.:

-

17. INFORMANT & ADDRESS:

Sara A. Chandler5192 Albemarle St.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Cardiac Collapse
(Old) Coronary Thrombosis

Interval Between Onset And Death

5 MIN.2 YRS.

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Diabetes mellitus (mild)3 YRS.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While at Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 1956 to May 28, 1956 that I last saw the deceased alive on May 24, 1956 and that death occurred at 8:10 PM from the causes and on the date stated above.

SIGNATURE (Degree or title) Herbert H. Weiger M.D. ADDRESS 6990 Piney Branch Rd., Wash. 12, D.C. DATE SIGNED

23. BURIAL, CREMATION, OR REMOVAL (Specify) 5-31-56 NAME OF CEMETERY OR CREMATORY Lincoln Crematory P.V. Soc. Co. Inc. LOCATION (City, town, or county) (State) Wash. D.C.

DATE RECD BY LOCAL REGISTRAR May 31-1956 REGISTRAR'S SIGNATURE Bessie M. Thompson 24. FUNERAL DIRECTOR The S. H. Hines Co ADDRESS 2901-14th St. N.W. Washington, D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S. AIR FORCE

W. A. C.

5266

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write OR and give nearest town) <u>Kensington</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write OR and give nearest town) <u>Kensington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3316 Kensington-Wheaton Rd</u>		STREET ADDRESS (If rural give location) <u>3316 Kensington-Wheaton Rd.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Clara Jane Clark</u>		DATE OF DEATH: <u>5</u> <u>19</u> <u>1956</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>July 20, 1866</u>
		9. AGE last birthday: <u>89</u> yrs	IF UNDER 1 YEAR: Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>—</u>	11. BIRTHPLACE (State or foreign country): <u>London England</u>
13. FATHER'S NAME: <u>Alfred F. Drew</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth Malpus</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS: <u>John D. Clark Wheaton Rd. - Kensington Md</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Coronary Heart Failure</u>			<u>1 m th</u>
ANTECEDENT CAUSE (B) <u>Arteriosclerosis</u>			<u>yr s</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Seriously Fractured Rt. Femur</u>			<u>yr s</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			<u>2 wks</u>
19A. DATE OF OPERATION: <u>5/18/56</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Fracture Rt. Femur</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21B. PLACE (Home, farm, factory, etc.) OF INJURY: <u>—</u>	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>—</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>5/18/56</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <u>(NO accident)</u>			
22. I hereby certify that I attended the deceased from <u>12/19/54</u> to <u>5/19/56</u> , that I last saw the deceased alive on <u>5/18/56</u> , 19 <u>56</u> , and that death occurred at <u>12:30 A.M.</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Samuel Allen</u>		DATE SIGNED <u>5/19/56</u>	
ADDRESS <u>M.D. Kensington, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Transit & Burial</u>		DATE THEREOF <u>5-19-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Wheatwood Cem</u>		LOCATION (City, town, or county) (State) <u>Philadelphia, Pennsylvania</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-19-56</u>		REGISTRAR'S SIGNATURE <u>Francis Patter</u>	
24. FUNERAL DIRECTOR <u>A.H. Hines Co.</u>		ADDRESS <u>Washington, D.C.</u>	

MARGIN RESERVE FOR INDEXING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. E.

MAY 25 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5267

CERTIFICATE OF DEATH

Reg. Dist. No.

05243
296

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle A. Last Connell				4. DATE OF DEATH Month May Day 22 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 7, 1883	
9. AGE (In years lost birthday) 72 yn.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman (Retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Washington, D. C.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME James Connell				14. MOTHER'S MAIDEN NAME Hanorah Mc Allen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service) Yes WWI				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intarction of Colon with peritonitis DUE TO Bronchopneumonia, both lungs DUE TO Tuberculosis, fibrocaceous, rt. lung. DUE TO Recurrent Epidermoid Carcinoma floor of mouth PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
INTERVAL BETWEEN ONSET AND DEATH 4 hours 2 days 7 y.s.							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from May 16 , 19 56 , to May 22 , 19 56 , that I last saw the deceased alive on May 22 , 19 56 , and that death occurred at L.OOP M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE John T. Binion M.D.				The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) John T. Binion, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/25/56		22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Warner G. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 25 1956	
				24b. REGISTRAR'S SIGNATURE Doris Thompson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NAVY V. S.

MAY 25 1956

RECEIVED

5268

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) The Clinical Center, Bethesda, Md.		d. STREET ADDRESS 3636-16th Street, N. W.	
3. NAME OF DECEASED (Type or print) First David Middle Pugsley Last Connery		4. DATE OF DEATH Month May Day 13 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 12, 1895
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR: Months 0 Days 1 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Administrative Assistant		10b. KIND OF BUSINESS OR INDUSTRY U.S. Senate	
11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Connery		14. MOTHER'S MAIDEN NAME Annie Pugsley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No (If yes, give year or dates of service)		16. SOCIAL SECURITY NO unknown	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the Pancreas DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour 0 p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from May 6 , 19 56 , to May 13 , 19 56 , that I last saw the deceased alive on May 13 , 19 56 , and that death occurred at 9:14 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 5/14/56 The National Institutes of Health Bethesda 14, Maryland			
ACTUAL SIGNATURE Claude E. Forkner, Jr. M.D.			
PHYSICIAN'S NAME (Type) Claude E. Forkner, Jr., M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 5-15-56	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Nassau Knolls	22d. LOCATION (City, town, or county) (State) Nassau N.Y.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR 16-56		24b. REGISTRAR'S SIGNATURE Bernie M. Thompson	

TO HOWARD OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MONDAY 15

11.8 10.1

5269

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Dist. of Columbia</u> (b. COUNTY <u>Washington</u>)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>5425 Connecticut Ave. N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Mildred</u> Middle <u>M.</u> Last <u>Loughlin</u>				4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 17 1904</u>	
9. AGE (In years last birthday) <u>52</u> yrs		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>		IF UNDER 24 HRS Hours <u>0</u> Min <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James L. Loughlin</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth L. Loughlin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1-1-1-1-1-1-1-1-1-1</u>		17. INFORMANT <u>Mrs. Elizabeth L. Loughlin</u>		Address <u>4-1-1-1-1-1-1-1-1-1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diffuse Multiple Myeloma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>None</u> DUE TO (c) <u>None</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 12</u> , 19 <u>56</u> , to <u>May 20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 19</u> , 19 <u>56</u> , and that death occurred at <u>1:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3921-14th St NW D.C.</u> DATE SIGNED <u>May 20 1956</u>							
ACTUAL SIGNATURE <u>Sidney C. Cousins</u> M.D. <u>3921-14th St NW D.C.</u>							
PHYSICIAN'S NAME (Type) <u>SIDNEY C. COUSINS</u> <u>3921-14th St NW D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 22, 1956</u>		<u>Ft. Lincoln Cemetery</u>		<u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. 2901 14th St. N.W.</u> <u>Washington 9, D. C.</u>				24a. REC'D BY REGISTRAR DATE <u>5-22-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: Affirm this certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8 1 0 1 1 1 1

1 1 1 1 1 1 1

5270
CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Taswell	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bandy	
c. LENGTH OF STAY IN 1b 34 days		d. STREET ADDRESS Route # 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, NIH		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cloy Middle May Last Crouse		4. DATE DEATH Month May Day 26 Year 19 56	
5. SEX F.	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 Sept. 1908
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Cochran		14. MOTHER'S MAIDEN NAME Cynthia Asbury	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Not available	
17. INFORMANT The Medical Record, Clinical Center, NIH		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute & Chronic Congestive Heart Failure & Hypertrophy DUE TO (b) Cardiac Curiosis; Metabolic & Electrolytic Imbalance DUE TO (c) Rheumatic Heart Disease (Mitral Stenosis & Tricuspid insufficiency) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) pyelonephritis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 5/26/56	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 22 April 19 56 , to 26 May 19 56 , that I last saw the deceased alive on 26 May 19 56 , and that death occurred at 10:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 120 Center Drive 13th floor, Maryland DATE SIGNED 5/27/56			
ACTUAL SIGNATURE Edward H. Sharp		M.D. Edward H. Sharp, M.D.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 5/28/56	
22c. NAME OF CEMETERY OR CREMATORY Richlands, Virginia		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co., 2901 14th St. N.W.		24a. REC'D BY REGISTRAR DATE 5-30-56	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. I.

JUN 1 1900



5271

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Travilah				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Travilah			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Agnes Middle M. Last CROWN				4. DATE OF DEATH Month May Day 17 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-14-1900	
9. AGE (In years last birthday) 55 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clarence Beane				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. No		17. INFORMANT Jessie Crown, Son Rt. 1 Rockville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEPATIC COMA, GENERALIZED METASTASIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DIABETES MELLITUS DUE TO (c) CARCINOMA OF BRONCHI							INTERVAL BETWEEN ONSET AND DEATH 24 HOURS 5 MONTHS 5 MONTHS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JANUARY 14, 1956 to MAY 17, 1956 , that I last saw the deceased alive on MAY 17, 1956 , and that death occurred 10:45 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Gordon S. Rosenberger				ADDRESS (Street, city or town, state) 310 W. MONTGOMERY AVE. ROCKVILLE, MD			
PHYSICIAN'S NAME (Type) Gordon S. Rosenberger, M.D.				DATE SIGNED MAY 17 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/20/1956		22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda				24a. REC'D BY REGISTRAR DATE 5/21/56		24b. REGISTRAR'S SIGNATURE Samuel Kratoch	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BURKE V. S.

MAY 20 1964

RECEIVED

5272

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE <u>District of Columbia</u> b. COUNTY <u>Columbia</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Philomena Rest Home</u>				d. STREET ADDRESS <u>3351 Tennyson St. N.W.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>BEATRICE J DANE</u>				4. DATE OF DEATH Month Day Year <u>May 3, 1956</u> <u>19</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 26, 1867</u>		9. AGE (In years last birthday) <u>88</u> yrs	10. IF UNDER 1 YEAR Months Days Hours Min <u>7</u> <u>7</u>	11. IF UNDER 24 HRS Hours Min <u>7</u> <u>7</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Jodon</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Glover</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Ruth Beatrice Dane</u>		Address <u>3351 Tennyson St. N.W. Wash DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>2200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Central arteriosclerosis - severe; general arteriosclerosis; aneurysm of aorta; atherosclerosis; thrombosis; arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 19, 1956</u> , to <u>May 3, 1956</u> , that I last saw the deceased alive on <u>April 19, 1956</u> , and that death occurred at <u>5:30 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5200 17th St N.W.</u> DATE SIGNED <u>May 3, 1956</u>							
ACTUAL SIGNATURE <u>Thomas E. Curtin</u> M.D.				DATE SIGNED <u>May 3, 1956</u>			
PHYSICIAN'S NAME (Type) <u>Thomas E. Curtin MD</u>				DATE SIGNED <u>May 3, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>5-3-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>5-4-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Gertrude B. Lawler</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 8 1964

5273

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN lb 5 hours		d. STREET ADDRESS 2347 Ashmeade Place, N.W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Kyle Last DAVENPORT		4. DATE OF DEATH Month May Day 6 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 March 1883
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Merchantile	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Travis DAVENPORT		14. MOTHER'S MAIDEN NAME Velle ANDREWS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT Mrs. Lena DAVENPORT (Wife)		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary embolism DUE TO (c) Atherosclerosis, widespread			INTERVAL BETWEEN ONSET AND DEATH 10 hrs 10 hrs 20 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary sclerosis			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6 May 19 56 , to 6 May 19 56 , that I last saw the deceased alive on 6 May 19 56 , and that death occurred at 6:40 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Wm B Ingram		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) William B. Ingram, CDR, MC, USN		DATE SIGNED 5/7/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10 May 1956	22c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery	22d. LOCATION (City, town, or county) (State) Spartanburg, South Carolina
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey		24a. REC'D BY REGISTRAR 5-7-56	
ADDRESS Bethesda, Md.		24b. REGISTRAR'S SIGNATURE Wm B. Ingram	
25. FUNERAL HOME R.A. Humphrey Funeral Home, 7557 Wisc. Ave.,		DATE 5-7-56	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be detached and filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
MAY 9 1956
BUREAU V. S.

5274

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE District of Columbia COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NNMC, Bethesda, Md.		d. STREET ADDRESS 1239 45th Place S.E.	
3. NAME OF DECEASED (Type or print) Harry Jacob DAVIES		4. DATE OF DEATH Month May Day 21 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 March 1875
9. AGE (In years last birthday) yrs 81		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY Mariner (Retired)	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Jacob DAVIES		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) WW-I WW-II (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mrs. Alice G. WEICKHARDT (Step-Daughter)		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction, Myocardial, Acute DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis, Coronary Arteries DUE TO (c) years(?)		INTERVAL BETWEEN ONSET AND DEATH 10 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral edema		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10 May , 19 56 , to 21 May , 19 56 , that I last saw the deceased alive on 21 May , 19 56 , and that death occurred at 6:55A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 5/21/56			
ACTUAL SIGNATURE Wm. B. Ingram M.D.		U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) William B. INGRAM, CDR, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-23-56	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE SIMMONS BROS., 2007 Nichols Ave., S.E. Wash, DC		24a. REC'D BY REGISTRAR DATE 5-21-56	
24b. REGISTRAR'S SIGNATURE Mary E. Russell			

BUREAU V. E.

1956. 8. 14

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

Item 19 Form 3-56 6-8-56 ans

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1/2 hr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Isabel</u> First Middle Last		4. DATE OF DEATH <u>5-22-1956</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-21-90</u>
9 AGE (In years last birthday) <u>65</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Scotland</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Martha McKnight</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16 SOCIAL SECURITY NO <u>061-20-6876A</u>	
17. INFORMANT <u>Mrs Daniel Callahan, Poolesville, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>to U.O. Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart Disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 22 1956</u> to <u>May 22 1956</u> that I last saw the deceased alive on <u>May 22 1956</u> , and that death occurred at <u>6 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George Sharpe</u> M.D.		ADDRESS (Street, city or town, state) <u>10644 Connecticut ave Kensington Md.</u>	
PHYSICIAN'S NAME (Type) <u>George Sharpe</u>		DATE SIGNED <u>5/22/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-24-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mount Airy Cemetery Bethesda - Md.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. B. Hilton, Barnesville, Md.</u>		24a. REC'D BY REGISTRAR <u>Charles W. Elgin</u> DATE <u>5/22/56</u>	
24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU OF

MAY 11 1900

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5233

CERTIFICATE OF DEATH

Reg. Dist. No.

052523
2-23

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE WASH. DC b. COUNTY D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON DC 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. & HOSP.		d. STREET ADDRESS 6622 5th St. NW	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle JAMES Last DEMING		4. DATE OF DEATH Month MAY Day 2 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-16-75
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GOV. EMP.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? AMERICA	
13. FATHER'S NAME ARTHUR DEMING		14. MOTHER'S MAIDEN NAME ADELAID AVERY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT ANNE L. DEMING		Address 6622 5th St. N.W. DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure DUE TO Hypertensive cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. OTIX (b) 104 yrs DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 3.1 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interference of left kidney & adrenal			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 1957 19 to May 2 19 56 that I last saw the deceased alive on May 2 19 56 and that death occurred at 3 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Kenneth F. Laughlin		ADDRESS (Street, city or town, state) 934 Ellsworth Rd Delmar, DE	
PHYSICIAN'S NAME (Type) KENNETH F. LAUGHLIN		DATE SIGNED 5-3-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 3, 1956	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	22d. LOCATION (City, town or county) (State) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Miller		24. REC'D BY REGISTRAR J. William Dordt	
ADDRESS 54 Carroll St. NW		DATE 5/4/56	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 7 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5276 CERTIFICATE OF DEATH

05253217
Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission), a. STATE <u>Maryland</u> b. COUNTY <u>ST. MARY'S</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Citney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridge</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Sharon Chronic Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Hanna</u> Middle <u>E.</u> Last <u>Dent</u>				4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 16, 1878</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		10c. BIRTHPLACE (State or foreign country)	
				<u>store keeper</u>		<u>St. Mary's County</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Green</u>				14. MOTHER'S MAIDEN NAME <u>Hanna Lumpkin-</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT <u>Mrs. Herman Mattingly</u> Address <u>Beltsville Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration + Coarctation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>For advanced Ca of Colon</u> DUE TO (c) <u>metastatic 4 yrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o.</u> <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Apr. 2</u> , 19 <u>56</u> , to <u>May 22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>22 May</u> , 19 <u>56</u> , and that death occurred at <u>2:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>John B. Ziegler</u> M.D. <u>John B. Ziegler</u> <u>22 May 1956</u> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/24/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. GEORGE'S EPISCOPAL VALLEY LEE</u>		22d. LOCATION (City, town, or county) (State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHARLES J. MATTINGLY</u>				ADDRESS <u>LEONARDTOWN MD.</u>		24a. REC'D BY REGISTRAR DATE <u>5/22/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Gertrude B. Lewis</u>			

BUREAU OF

MAY 23 1956

U.S. DEPT. OF JUSTICE

5277

CERTIFICATE OF DEATH

05254

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg				c. LENGTH OF STAY IN 1b 6 Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ammons Nursing Home				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Idella Middle Prather Last Diggs				4. DATE OF DEATH Month May Day 11 Year 1956			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 28, 1872		9. AGE (In years last birthday) 84 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Levi Prather				14. MOTHER'S MAIDEN NAME Susan Simpson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT George Diggs Gaithersburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage # 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral Arteriosclerosis DUE TO (c) Hypertensive Cardio-renal Disease						INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arthritis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Laurel				20g. (County) Montgomery		20h. (State) Md.	
21. I certify that I attended the deceased from January 30, 1956 to May 11, 1956 , that I last saw the deceased alive on May 10, 1956 , and that death occurred at Laurel, Md. from the causes and on the date stated above.							
ACTUAL SIGNATURE Webster Sewell M.D.				ADDRESS (Street, City or town, state) Norbeck Rt 1			
DATE SIGNED 5-13-56							
PHYSICIAN'S NAME (Type) WEBSTER SEWELL Seloe Spring Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/14/56		22c. NAME OF CEMETERY OR CREMATORY Brooke Grove		22d. LOCATION (City, town, or county) (State) Laytonsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sunday				ADDRESS Rookville, Md.		24a. REC'D BY REGISTRAR DATE May 15/56	
				24b. REGISTRAR'S SIGNATURE Wanda L. Hood			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. This certificate is to be signed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate is filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 2 11

5234

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakewood Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakewood Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph J. Joseph Donovan</u>		4. DATE OF DEATH Month Day Year <u>May 12 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-1-51</u>
9. AGE (In years last birthday) <u>68</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>cab driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>American</u>	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>John Donovan</u>		14. MOTHER'S MAIDEN NAME <u>Anna Crowley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-01-9016</u>	
17. INFORMANT <u>Mrs. Sylvia Donovan</u>		Address <u>(Same)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Esophagus</u> <u>150X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>9 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>August 12, 1955</u> to <u>May 12, 1956</u> , that I last saw the deceased alive on <u>May 12, 1956</u> , and that death occurred at <u>9:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. M. Whitlock</u>		DATE SIGNED <u>May 13/56</u>	
PHYSICIAN'S NAME (Type) <u>J. M. WHITLOCK</u>		ADDRESS (Street, city or town, state) <u>Washington Sanitarium</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>May 16, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>SUITLAND, PR GEO. G. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walter</u>		24a. REC'D BY REGISTRAR <u>5/14/56</u>	24b. REGISTRAR'S SIGNATURE <u>J. Wilson Dodd</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED V. S.

MAY 15 1911

101-101

Reg. Dist. No. 277

5278

VS. AISME(S)
SM 9/55

U. S. A. 1917

5279

CERTIFICATE OF DEATH

Reg. Dist. No. 215

05257.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN lb 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 304 Sycamore St.			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Veronica Last DREWES				4. DATE OF DEATH Month May Day 29 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1 Feb. 1904	
9. AGE (In years last birthday) 52 yrs		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) New Jersey				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Patrick Brennan				14. MOTHER'S MAIDEN NAME Johanna Brennan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (Son) Albert J. DREWES (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis, widespread DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 3 days Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 26 May , 19 56 , to 29 May , 19 56 , that I last saw the deceased alive on 29 May , 19 56 , and that death occurred at 7:00P M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE R.R. Brandon, Lt. MC USNR M.D. U.S. Naval Hospital, NNMC, Bethesda, Md. 5/31/56							
PHYSICIAN'S NAME (Type) R.R. BRANDON, LT, MC, USNR U.S. Naval Hospital, NNMC, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1 June 1956		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Fitzgerald Funeral Home				ADDRESS Arlington, Va. 3245 Wilson Blvd.		24a. REC'D BY REGISTRAR DATE 5-30-56	
24b. REGISTRAR'S SIGNATURE Wayne E. Russell							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 7 1966

RECEIVED

DATE SIGNED _____

5/21/56

VS. A15ME(5)
SM 9/55

REAU V. B.

MAY 25 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5281

CERTIFICATE OF DEATH

05259

Item 10a: film 6178 6-4-56L

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Etneg</u> <u>2170.1W</u> c. LENGTH OF STAY IN 1b. <u>Rockville</u> d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Sharon Chronic Hospital</u> 1013 De Beck Drive				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>1013 De Beck Drive</u>			
3. NAME OF DECEASED (Type or print) First <u>Rupert</u> Middle <u>Ebner</u> Last <u>Ebner</u>				4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec-27-1885</u>	
9. AGE (In years) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>16</u>		IF UNDER 24 HRS. Hours <u>10</u> Min <u>00</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BAKER Retired</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Vienna Austria</u>				11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Rupert Stengel</u>			
14. MOTHER'S MAIDEN NAME <u>Anna</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>488-01-7464</u>				17. INFORMANT <u>Mrs. Anna Colby</u> <u>1013 De Beck Drive Rockville-Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute sub-arachnoid hemorrhage</u> <u>443A</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Sen. Arteriosclerosis + Hypertension</u> DUE TO (c) <u>Cardio-vascular disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>5 MARCH</u> , 19 <u>56</u> , to <u>13 MAY</u> , 19 <u>56</u> that I last saw the deceased alive on <u>13 MAY</u> , 19 <u>56</u> , and that death occurred at <u>3:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL PHYSICIAN'S NAME (Type) <u>John Bosley Ziegler</u> M.D.				ADDRESS (Street, city or town, state) <u>Alney, Md</u>			
DATE SIGNED <u>13 MAY 56</u>				22a. REC'D BY REGISTRAR <u>5-18-56</u>			
22b. REGISTRAR'S SIGNATURE <u>Esther B. Lawler</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Missouri Cemetery</u>			
22d. LOCATION (City, town, or county) (State) <u>St. Louis</u> <u>Missouri</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>			
ADDRESS <u>Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>5-18-56</u>			
24b. REGISTRAR'S SIGNATURE <u>Esther B. Lawler</u>				24c. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 23 1936

RECEIVED

BUREAU V. S.

MAY 25 1950

RECEIVED

5283

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 80 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Clinical Center, National Inst. of Health				d. STREET ADDRESS New Market			
3. NAME OF DECEASED (Type or print) First Cleo Middle Grace Last Eyler				4. DATE OF DEATH Month May Day 26 Year 19 56			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 June 1916		9. AGE (In years last birthday) 39 yrs		IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ray Stevens				14. MOTHER'S MAIDEN NAME Bessie Long			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-14-9344		17. INFORMANT Address The Medical Record, Clinical Center			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Obstruction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malignant Melanoma DUE TO (c) 2 yrs.						INTERVAL BETWEEN ONSET AND DEATH 3-4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 March , 19 56 , to 26 May , 19 56 , that I last saw the deceased alive on 26 May , 19 56 , and that death occurred at 6.00 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard D. Fritz M.D.				ADDRESS (Street, city or town, state) 3 Peaks Hill Rd. Bethesda, Md.			
PHYSICIAN'S NAME (Type) Richard D. Fritz				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/29/56		22c. NAME OF CEMETERY OR CREMATORY Rocky Hill		22d. LOCATION (City, town, or county) (State) nr. Woodsboro Md	
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Barton ADDRESS Walkersville, Md				24a. RECEIVED BY REGISTRAR DATE 3/1/56		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

MEDICAL CERTIFICATION

TO HOSTS OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

ON 1 1900

RECEIVED

5235

CERTIFICATE OF DEATH

Reg. Dist. No.

05262
223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>—</u> b. COUNTY <u>—</u> v	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>May</u> Last <u>Fischer</u>		4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1956</u> 19	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-5-83</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Am</u>	
13. FATHER'S NAME <u>John Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Emma O. Mangum</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Tamponade</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <u>Atherosclerosis + stenosis</u> DUE TO (c) <u>Cardio-vasc. heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Termined</u> <u>Years?</u> <u>Years?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5-25-1956</u> , to <u>5-30-1956</u> , that I last saw the deceased alive on <u>5-29-1956</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Hare</u> M.D.		ADDRESS (Street, city or town, state) <u>Takoma Park Md</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>		DATE SIGNED <u>5/30/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/2/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Beltsville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thos. J. H. Finner</u>		24a. REC'D BY REGISTRAR <u>6/1/56</u>	
ADDRESS <u>2901 14th St. N.W. Washington, D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>J. Edgar Hoover</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

JOHN A. DUNN

1961



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

214

5284

1. PLACE OF DEATH II. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8242 Georgia Ave.				d. STREET ADDRESS 1414 UNDERWOOD STREET, N.W.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) DR. SAMUEL First Middle Last FISHMAN				4. DATE OF DEATH Month Day Year MAY 30 19 56			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 6, 1908		9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHYSICIAN			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME LOUIS FISHMAN				14. MOTHER'S MAIDEN NAME HANNAH HENDEL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mrs. Tillie Fishman, 1414 Underwood St., N.W. Washington, D. C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </div> <div style="width: 45%;"> (b) DUE TO (c) </div> </div> </div>							INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE Frank J. Broschart M.D. EXAMINER'S NAME (Type) Frank J. Broschart				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 1, 1956		22c. NAME OF CEMETERY OR CREMATORY Adas Israel Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE B. Waugansky & Son				ADDRESS 3501-14 St...		24a. REC'D BY REGISTRAR DATE 6/5/56	
24b. REGISTRAR'S SIGNATURE James Potter							

TO DE BE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only a portion is necessary, please execute in full. State, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1/2 1/2

5285

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>MONTGOMERY</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>MONTGOMERY</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BETHESDA</u>		LENGTH OF STAY (in this place) <u>2 YRS.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BETHESDA</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>5202 WESTWOOD DRIVE</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>WILLIAM FREDERICK FOSHAG</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 21 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, (MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>MAR. 17, 1894</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCIENTIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVT</u>		11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM F. FOSHAG</u>				14. MOTHER'S MAIDEN NAME <u>EVA REIGLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>MERLE FOSHAG 5202 WESTWOOD DRIVE</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Thrombocytopenic purpura</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic myeloid leukemia</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Essential hypertension</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 1952....., to ... 5/21....., 1956....., that I last saw the deceased alive on..... 5/16/..... 1956....., and that death occurred at..... 7:00AM, from the causes and on the date stated above.							
SIGNATURE <u>Joseph M. Hawler</u> M.D. 900 - 17th St., N.W.				ADDRESS (Street, city, town, state) DATE SIGNED <u>5/21/56</u> (State)			
23. BURIAL, CREMATION, (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Cremation</u>		<u>5/23/1956</u>		<u>Cedar Hill Crematory</u>		<u>Suitland, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>5-25-56</u>		<u>Barbara M. Thompson</u>		<u>Joseph M. Hawler's Sons</u>		<u>WASH. DC.</u>	

1 INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU V. S.

MAY 29 1900

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05264

5250

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>3 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>502 Dean Drive</u>				d. STREET ADDRESS <u>502 Dean Drive</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>JEWETT</u> Last <u>FOSTER</u>				4. DATE OF DEATH Month <u>May</u> Day <u>18</u> , Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 22-1905</u>		9. AGE (In years last birthday) <u>51</u> yrs	IF UNDER 1 YEAR Months <u>2</u> Day <u>26</u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service Sta. Attend.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gas Station</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Foster</u>				14. MOTHER'S MAIDEN NAME <u>Nanette Jewett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>578-0343267</u>		17. INFORMANT <u>W.B. Markham Stepson</u>		Address <u>Above</u>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Coronary occlusive myocardial infarct.</u> DUE TO (c) <u>coronary arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u> <u>1 week</u> <u>Indef</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/1/54</u> , to <u>5/18/56</u> , that I last saw the deceased alive on <u>5/18/56</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stephen M. Jones</u> M.D.				ADDRESS (Street, city or town, state) <u>Rockville, Md.</u>		DATE SIGNED <u>5/19/56</u>	
PHYSICIAN'S NAME (Type) <u>Stephen M. Jones</u>				<u>Rockville, Md.</u>		<u>5/19/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-21-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattsville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>5/21/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Laurel Kratochvil per EC.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WOMEN'S A. S.

MAY

RECEIVED

5236

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
c. LENGTH OF STAY IN 1b <u>6 days.</u>		d. STREET ADDRESS <u>2801 31st St. S.E.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanit Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr Robert Berle Frazier</u>		4. DATE OF DEATH Month Day Year <u>May 12 1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26 1905</u>		
9. AGE (In years last birthday) <u>50</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Health Educ. + Welfare Dept. (clerk)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Indiana</u>			
11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Novel L. Frazier</u>		14. MOTHER'S MAIDEN NAME <u>Luella Graham</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>U.S. #2</u>		16. SOCIAL SECURITY NO. <u>Hospital records -</u>			
17. INFORMANT Address <u>Hospital records -</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO (b) <u>Thrombophlebitis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs 45 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma w/ bladder</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>5/12</u> , 19 <u>56</u> , to <u>5/12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5/12</u> , 19 <u>56</u> , and that death occurred at <u>4:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur J. Willets</u> M.D. <u>909 Pershing Drive, Silver Spring, Md.</u>		ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Arthur J. Willets</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>			
22b. DATE THEREOF <u>5/15/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl. Cem.</u>			
22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>The S. N. Hines Co. 2901-14th St. NW Washington, D.C.</u>			
24a. REC'D BY REGISTRAR DATE <u>5/17/56</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Willets</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. GOVERNMENT

1911

OFFICE OF THE
COMMISSIONER OF THE
GENERAL LAND OFFICE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5286 CERTIFICATE OF DEATH

05266

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>4hr.34 min.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, NMMC, Bethesda, Md.</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>4525 Buchanan Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Anna GIBBARD</u>		4. DATE OF DEATH Month Day Year <u>May 23 1956</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>5-23-56</u>		9. AGE (In years last birthday) yrs Months Days Hours Min. <u>4 34</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>				11. BIRTHPLACE (State or foreign country) <u>Bethesda, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Foy Wallace GIBBARD</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Virginia CARTER</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>(Father) Foy Wallace GIBBARD (Same As #2)</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) _____										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>23 May</u> , 19 <u>56</u> , to <u>23 May</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>23 May</u> , 19 <u>56</u> , and that death occurred at <u>9:35 P.M.</u> , from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>J.W. Stohlman III (M.C.) USNR</u>				ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u>				DATE SIGNED <u>5-24-56</u>			
PHYSICIAN'S NAME (Type) <u>J.W. STOHLMAN, III, LT, MC, USNR</u>				<u>U.S. Naval Hospital, Bethesda, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-26-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Fiedler</u>						ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>4-23-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Cassel</u>	
Francis GASCH'S Sons 4739 Baltimore Ave.,											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. F.

MAY 25 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
Items 8: & 9: Film 3198										
6/6/56 dmr. 5287										
CERTIFICATE OF DEATH										
Reg. Dist. No. 05267										
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					c. LENGTH OF STAY IN 1b <u>6 yrs</u>					
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					X					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7810 Moreland Lane</u>					d. STREET ADDRESS <u>7810 Moreland Lane</u>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>WILLIAM</u> Last <u>GIERBERG</u>					4. DATE OF DEATH Month <u>May</u> Day <u>25</u> Year <u>19 56</u>					
5 SEX <u>Male</u>		6 COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-11-1888</u>		9. AGE (In years) <u>67</u> yrs		
						IF UNDER 1 YEAR Months <u>5</u> Days <u>14</u> Hours <u></u> Min <u></u>		IF UNDER 24 HRS Hours <u></u> Min <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Gustav Giersberg</u>					14. MOTHER'S MAIDEN NAME <u>Anna Yanke</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>					16. SOCIAL SECURITY NO. <u>058-04-4372</u>		17. INFORMANT <u>Kathryn S. Power, Dau. Item 2</u>			
					Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Starvation - Coma -</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral-Vascular Accident -</u> DUE TO (c) <u>Cardiovascular Disease -</u> INTERVAL BETWEEN ONSET AND DEATH - <u>2 weeks -</u> <u>2 weeks -</u> <u>1st Attack 1952.</u> <u>20 yrs.</u>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma - Prostate - & Metastasis - to - Pelvis - Spine - Lungs -</u>										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>23 Jan -</u> , <u>1952</u> , to <u>25 May</u> , <u>1956</u> , that I last saw the deceased alive on <u>14 May</u> , <u>1956</u> , and that death occurred at <u>7:00 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7936 Bengtson Rd.</u> DATE SIGNED <u>25 May 56</u> ACTUAL SIGNATURE <u>John G. Ball</u> M.D. <u>Bethesda 14 Md</u> PHYSICIAN'S NAME (Type) <u>John G. Ball</u>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>			22b. DATE THEREOF <u>5-26-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>			22d. LOCATION (City, town, or county) (State) <u>Pleasantville N.Y.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>					ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>5-28-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

RECEIVED
MAY 29 1956
BUREAU V. S.

5288

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>20 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. STREET ADDRESS <u>9213 Columbia Blvd</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>William</u> Last <u>Gill</u>		4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 28 1906</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS, OR INDUSTRY <u>Private Practice</u>	
11. BIRTHPLACE (State or foreign country) <u>Mississippi</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM ALVIN GILL</u>		14. MOTHER'S MAIDEN NAME <u>MARCEY STEVENS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-09-3763</u>	
17. INFORMANT <u>MRS. Ruth M. Gill</u>		Address <u>9213 Columbia Blvd Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Heart Disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0. 11.</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 10, 1956</u> to <u>May 12, 1956</u> , that I last saw the deceased alive on <u>May 12, 1956</u> , and that death occurred at <u>12:42</u> M., from the causes and on the date stated above. — ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Marion Bankhead</u> M.D.		9241 Col. Blvd. 5/14/56	
PHYSICIAN'S NAME (Type) <u>J. Marion Bankhead</u>		<u>Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 15, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Union Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	
24a. REC'D BY REGISTRAR <u>5/16/56</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Beanie Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours of death.

Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detailed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

1954

5289

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton, Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SHARON CHRONIC HOSP</u>		d. STREET ADDRESS <u>10406 Ga. Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Lillie</u> Middle <u>Gleason</u> Last <u></u>		4. DATE OF DEATH Month <u>May</u> Day <u>31</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 4, 1870</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Charles W. Cramer</u>		14. MOTHER'S MAIDEN NAME <u>Martha Biggs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Tomagni, 10406 Ga. Ave Wheaton Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma stomach - far advanced gen. metastatic</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 22, 1955</u> to <u>May 31, 1956</u> , that I last saw the deceased alive on <u>May 24, 1956</u> , and that death occurred at <u>6:05 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John Bosley Ziegler</u> M.D.		ADDRESS (Street, city or town, state) <u>Olney Md</u> DATE SIGNED <u>May 31, 1956</u>	
PHYSICIAN'S NAME (Type) <u>John Bosley Ziegler</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/2/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. 2901-14 St NW</u>		24a. REC'D BY REGISTRAR <u>DATE 5-31-56</u> 24b. REGISTRAR'S SIGNATURE <u>Kertrud B. Lawler</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ROBERT A. S.

1955

1955

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5290

CERTIFICATE OF DEATH

Reg. Dist. No. 05250

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
				d. STREET ADDRESS 520 4th St., S.E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy GOODINE				4. DATE OF DEATH Month Day Year May 12 19 56			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10 May 1956	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months Days Hours Min					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY Infant			
11. BIRTHPLACE (State or foreign country) Infant				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Robert GOODINE, Jr.				14. MOTHER'S MAIDEN NAME Lois Gladys ADAMS (S)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT (Mother) Lois G. GOODINE (Same As #2)				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PERICARDIAL EFFUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) INTERVENTRICULAR SEPTAL DEFECT DUE TO (c) 2 DAYS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 12 HRS							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10 May 1956 , to 12 May 1956 , that I last saw the deceased alive on 12 May 1956 , and that death occurred at 3:07 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, NNMC, Bethesda, Md. 5/14/56 ACTUAL SIGNATURE J.W. STOLHMAN, III, LT, MC, USN PHYSICIAN'S NAME (Type) J.W. STOLHMAN, III, LT, MC, USN U.S. Naval Hospital, NNMC, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 5-16-56			
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery				22d. LOCATION (City, town, or county) (State) Arlington, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE CHINN Funeral Home 2605 Seminary Rd. Arl. Va.				24a. REC'D BY REGISTRAR DATE 5-14-56			
				24b. REGISTRAR'S SIGNATURE May E. Cassell			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. By the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

W. A. RYAN

1910

1910

TO DEPARTMENT OF HEALTH: This certificate should be executed within 24 hours after death. If any necessary, please enclose a copy of the death certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the registrar. Give Page 5 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5291 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05271
Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5420 Goldsboro Rd.</u>		d. STREET ADDRESS <u>Goldsboro Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Eunice</u> Middle <u>C.</u> Last <u>Goodwin</u>		4. DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1956</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 19, 1924</u>
9. AGE (In years last birthday) <u>31</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>27</u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel A. Clayton</u>		14. MOTHER'S MAIDEN NAME <u>Amye Purcell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Leo Goodwin - Item # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>Y73.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Carbon monoxide poisoning</u> (a), stating the underlying cause lost. DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found dead in garage with door closed, motor had been running.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>5/17/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-19-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George, Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>5-21-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>			

1997

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05272

5292

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>9518 Colesville Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Leopold J. Guggenberger</u>		4. DATE OF DEATH <u>5-25-1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/31/1879</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Salesman</u>	
11. BIRTH PLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leopold Guggenberger</u>		14. MOTHER'S MAIDEN NAME <u>Scottha Kumpf</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>330-26-4337</u>	
17. INFORMANT <u>Emily J. Rinschde</u>		Address <u>Brooklyn</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive Heart Disease</u> DUE TO <u>Nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1942</u> , to <u>May 25, 1956</u> , that I last saw the deceased alive on <u>May 14, 1956</u> , and that death occurred at <u>3:55 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John N. Andrews</u>		ADDRESS (Street, city or town, state) <u>960 Colesville Rd</u>	
PHYSICIAN'S NAME (Type) <u>John N. Andrews M.D.</u>		DATE SIGNED <u>5-25-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/28/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Bronx N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Chambers Co</u>		ADDRESS <u>1400 Chapin St N.W.</u>	
24a. REC'D BY REGISTRAR <u>5/29/56</u>		24b. REGISTRAR'S SIGNATURE <u>Francis</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 4 1900

RECEIVED
JUN 4 1900

72

211

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05273

CERTIFICATE OF DEATH

5251

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY		Montgomery		STATE		D.C.	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		Rockville		COUNTY		Washington	
TOWN		Rockville		CITY (If outside corporate limits, write RURAL and give nearest town)		Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Congressional Manor Sanit. 12201 Rockville Pike		STREET ADDRESS		4304 18th St. N.W.	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
Gertrude				May 11 1956			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
female		white		married		3/3/1866	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday		11. BIRTHPLACE (State or foreign country)	
housewife		at home		90 yrs.		Virginia	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Joseph Kelley				unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
no				-			
17. INFORMANT & ADDRESS				Sanitarium records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				Hypostatic Pneumonia			
ANTECEDENT CAUSE(S) DUE TO (B)				Cardiac Decompensation			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				Arteriosclerotic Heart Disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				Diabetes Mellitus			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
				None			
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21e. INJURY OCCURRED While at work or Not while at work			
None				None			
22. I hereby certify that I attended the deceased from July 24, 1941, to May 11, 1956, that I last saw the deceased alive on May 10, 1956, and that death occurred at 3:20 A.M. from the causes and on the date stated above.				22. HOW DID INJURY OCCUR?			
SIGNATURE				DATE SIGNED			
Glen Pincock				5/11/56			
ADDRESS (Street, city, town, state)				1944 Seminary Rd Silver Spring, Md			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
burial		5/14/56		Union Cemetery		Leesburg, Virginia	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 10/14/56		Laurel H. Kinglarp		2901 14th St. N.W., Wash. D.C.		The S.H.Hines Co.	

STANDARD

MAY 15 19

1919

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5237

CERTIFICATE OF DEATH

05274

Reg. Dist. No. 173

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>117x</i> b. COUNTY <i>District of Columbia</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lakewood Park</i>				c. LENGTH OF STAY IN 1b <i>11 hours</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>				d. STREET ADDRESS <i>8 Walnut St., N.W.</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>Mabel</i> Middle <i>Florence</i> Last <i>Hackett</i>		4. DATE OF DEATH Month <i>5</i> Day <i>12</i> Year <i>1956</i>					
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Cauc.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-16-02</i>	9. AGE (In years last birthday) <i>54 yrs</i>	IF UNDER 1 YEAR Months <i>54</i> Days <i>12</i> Hours <i>19</i> Min.	IF UNDER 24 HRS. Months <i>54</i> Days <i>12</i> Hours <i>19</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Chicago, Ill.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Stokke</i>				14. MOTHER'S MAIDEN NAME <i>Maria Ryerson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <i>Washington Sanitarium & Hospital Records</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest with myocardial failure</i>							
DUE TO (b) <i>Post-operative shock</i>							
DUE TO (c) <i>Hypertensive vascular disease</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <i>Acute cholecystitis + cholelithiasis GB removed 5-11-56 at 6:30 PM</i>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>no injury</i>					
20c. TIME OF INJURY Month, Day, Year Hour <i>a. 1.</i> p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5/12/56</i> to <i>5/12/56</i> , that I last saw the deceased alive on <i>5/12/56</i> , and that death occurred at <i>12:10 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Frank L. Williamson</i> M.D.				DATE SIGNED <i>5/12/56</i>			
PHYSICIAN'S NAME (Type) <i>Frank L. Williamson</i>				<i>Washington, D.C.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>May 15, 1956</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Beachgrove Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Montgomery Indiana</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters</i>		ADDRESS <i>254 Carroll St NW</i>		24a. REC'D BY REGISTRAR DATE <i>5/15/56</i>		24b. REGISTRAR'S SIGNATURE <i>J. Arthur Walters</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be used by the hospital or attending physician. The law requires that the death certificate be executed within 48 hours after death. Page 4 may be used by the hospital or attending physician.

RECEIVED
MAY 14 1938
BUREAU V. S.

1
 ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be filed with the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 195275 05274

5293

CERTIFICATE OF DEATH

Reg. Dist. No. 18

1. PLACE OF DEATH a. COUNTY <u>Montg</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>				c. LENGTH OF STAY IN 1b <u>12yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>7- Montg. Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emily</u> Middle <u>W. Lyddane</u> Last <u>Hall</u>				4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 21-1884</u>		9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>16</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home Work</u>		11. BIRTHPLACE (State or foreign country) <u>Montg Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William J. Williams</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth A Schaeffer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Virginia Darby. Gaithersburg. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of pancreas</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with generalized metastasis</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-1</u> , 19 <u>56</u> , to <u>5-7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-6</u> , 19 <u>56</u> , and that death occurred at <u>2 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>F. J. Brosch</u>		M.D. <u>Gaithersburg Md 5-8-56</u>					
PHYSICIAN'S NAME (Type) <u>FRANK J. BROSCH M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-10-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>		22d. LOCATION (City, town, or county) (State) <u>Beallsville. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner,</u>				ADDRESS <u>Gaithersburg. Md.</u>		24a. REC'D BY REGISTRAR DATE <u>May 9-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Abigail L. Cooke</u>			

BUREAU V. S.

MAY

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5294

CERTIFICATE OF DEATH

05276

214

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY MONTGOMERY		STATE MARYLAND		COUNTY MONTGOMERY			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN SILVER SPRING		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN SILVER SPRING			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 9525 THORNHILL ROAD				STREET ADDRESS (If rural give location) 9525 THORNHILL ROAD			
3. NAME OF DECEASED (First) (Middle) (Last) FANNIE M HALLEY				4. DATE OF DEATH (Month) (Day) (Year) MAY 19 19 56			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH JULY 1, 1867		9. AGE last birthday 88 yrs.	IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMELAKER - RETIRED			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME CHARLES JAMES				14. MOTHER'S MAIDEN NAME SUSAN HUTCHISON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-18-6743-D		17. INFORMANT & ADDRESS Mr. Eugene Halley, 9525 Thornhill Rd. Silver Spring, Md.			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Uremia						2 weeks	
ANTECEDENT CAUSE(S) DUE TO (B) Hypertension, Cerebro-renal vascular disease						1 1/2 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Senile Dementia						3 yrs	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Diabetes Mellitus						1.2 yrs	
Chronic Angina (Chronic)						3 yrs	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 1944, to May 19, 1956, that I last saw the deceased alive on May 13, 1956, and that death occurred at 11:30 A.M. from the causes and on the date stated above.							
SIGNATURE Lester W. Harris				ADDRESS (Street, city, town, state) 1011 Lakeside Rd Silver Spring Md		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 5/22/56		NAME OF CEMETERY OR CREMATORY CONGRESSIONAL CEMETERY		LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
24. REC'D BY REGISTRAR DATE 5/24/56		REGISTRAR'S SIGNATURE Francis L. Latta		25. FUNERAL DIRECTOR'S SIGNATURE Warner P. Murphy		ADDRESS SILVER SPRING, MD.	

BUREAU Y. 2

MAY 28 1950

RECEIVED
MAY 28 1950

CERTIFICATE OF DEATH

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Woodfield		c. LENGTH OF STAY IN lb 10 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. Gaithersburg		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Viola Middle Virginia Last Hamilton		4. DATE OF DEATH Month May Day 12 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 13, 1874
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min.	11. IF UNDER 24 HRS Months 10 Days 10 Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Frederick Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joshua Stup		14. MOTHER'S MAIDEN NAME L. Virginia Zimmerman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no. or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Earl Hamilton, Gaithersburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 15, 1951 to May 12, 1956 , that I last saw the deceased alive on May 10, 1956 , and that death occurred at 9:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James P. Kerr		DATE SIGNED 5/14/56	
PHYSICIAN'S NAME (Type) James P. Kerr M.D.		Damascus, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 15, 1956	
22c. NAME OF CEMETERY OR CREMATORY Wesley Grove		22d. LOCATION (City, town, or county) (State) Woodfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. L. Moberg		24a. REC'D BY REGISTRAR DATE May 14/56	
ADDRESS Damascus, Md.		24b. REGISTRAR'S SIGNATURE Della H. Burdette	

S. A. Dwyer

1900

5296

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE md b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Alta Vista Rest Home				d. STREET ADDRESS 3712 Bradley La			
3. NAME OF DECEASED (Type or print) Hand First Elizabeth Middle Agnes Last HAND				4. DATE OF DEATH May 31, 1956			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 12, 1892	9. AGE (In years last birthday) 63 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months 6 Days 22 Hours 3 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Milled				14. MOTHER'S MAIDEN NAME Agnes Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT John Hand Address Ch. Ch. Md. 3618 Raymond St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Left Ventricular Failure DUE TO acute Pulmonary Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerotic DUE TO Hypertensive Heart disease (c) Hypertensive Heart disease						INTERVAL BETWEEN ONSET AND DEATH 9 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from June 1954 to May 31, 1956 , that I last saw the deceased alive on 5-31-56 and that death occurred at 12:05 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE P. P. Andrews M.D.				ADDRESS (Street, city or town, state) 4201 Fessenden St. N.W. Washington			
PHYSICIAN'S NAME (Type) P. P. ANDREWS MD				DATE SIGNED 5-31-56 N.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit		22b. DATE THEREOF 6-8-56		22c. NAME OF CEMETERY OR CREMATORY The Pines		22d. LOCATION (City, town, or county) (State) Opportunity Wash	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda Md.		24a. REC'D BY REGISTRAR DATE 5-31-56	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

052724

Reg. Dist. No.

5297

1. PLACE OF DEATH a. COUNTY <u>Montg</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2212 Washington Ave</u>		d. STREET ADDRESS <u>2212 Washington Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Caroline Elizabeth Harkins</u>		4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-3-1918</u>
9. AGE (In years last birthday) <u>37</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pa</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USC</u>	
13. FATHER'S NAME <u>John P. Aderhold</u>		14. MOTHER'S MAIDEN NAME <u>Grace Salbo</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Year, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>206-10-7512</u>	
17. INFORMANT <u>Richard Harkins (Husband)</u>		Address <u>Same as Dec. 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>5-24-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>		22b. DATE THEREOF <u>5/24/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bradford Co. Mem. Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Luther Mills, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. B. Humphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	
24a. REC'D BY REGISTRAR <u>5/29/56</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Latta</u>	

TO DEPARTMENT OF HEALTH: This certificate should be executed within 24 hours after death. If any necessary, please execute and forward to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JUN 1 1966

U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

CERTIFICATE OF DEATH

Reg. Dist. No.

24

5298

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>4 yrs</u>				d. STREET ADDRESS <u>1923 - East West Hwy</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1923 - East West Hwy</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>T</u> Last <u>HEFFNER</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>6</u> Year <u>1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN, 30</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>NW Hampshire</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Michael O'Malley</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Teresa</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>H. C. Edwards, Edward P. Heffner 1923 - East West Hwy</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>400.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>anticoagulation</u> DUE TO (c) <u>anticoagulation</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No injury</u>			
20c. TIME OF INJURY Month, Day, Year Hour p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 1954</u> , to <u>May 6, 1956</u> , that I last saw the deceased alive on <u>May 6, 1956</u> , and that death occurred at <u>7:20 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Helen J. de S. Coutinho</u> M.D. <u>1890 - Ontario PR. N.W. Wash. D.C.</u>							
PHYSICIAN'S NAME (Type) <u>HELEN J. de S. COUTINHO</u> <u>1890 ONTARIO PL. N.W. - WASH. D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>5-9-56</u>		<u>St. Agnes</u>		<u>St. Agnes - DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Funeral Home 3831 - E. W. - NW</u>				24a. REC'D BY REGISTRAR DATE <u>5-16-56</u>		24b. REGISTRAR'S SIGNATURE <u>Carroll - attn</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the attending physician or the funeral director. After this certificate has been signed by the attending physician on completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 9 1955

RECEIVED

05281
Reg. Dist. No. 276

1. PLACE OF DEATH o. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE West Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Walton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda, Md.				d. STREET ADDRESS none	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Bette		First Annette Middle Hensley Last		4. DATE OF DEATH Month May Day 10 , Year 56	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH October 1, 1949		9. AGE (In years last birthday) yrs. 6		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Hensley		14. MOTHER'S MAIDEN NAME Bette Miller	
15. WAS DECEASED EVER IN U. S. ARMY FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) intracranial hemorrhage DUE TO 40 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) bronchopneumonia DUE TO acute lymphocytic leukemia (c) acute lymphocytic leukemia					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from April 30, 1956 to May 10, 1956 , that I last saw the deceased alive on May 10, 1956 , and that death occurred at 1:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 5/10/56 ACTUAL SIGNATURE Mehran Goulia M.D. Mehran Goulia The National Institutes of Health PHYSICIAN'S NAME (Type) Mehran Goulia M.D. Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-13-56		22c. NAME OF CEMETERY OR CREMATORY Lventide Cemetery	
22d. LOCATION (City, town, or county) Spencer		(State) W. Va.			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 5-11-56	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson					

BUREAU V. S.

1900

1900

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05282 4

Reg. Dist. No.

5300

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1309 LANSDOWNE WAY</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BERTHA</u> Middle <u>KNOXES</u> Last <u>HESLET</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>4</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 14, 1878</u> 84 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BENJAMIN LACEY KNOXES</u>		14. MOTHER'S MAIDEN NAME <u>RHODA ANN LANSDOWNE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>ACOE</u>	
17. INFORMANT <u>MARY R. HESLET</u> Address <u>1309 LANSDOWNE WAY S.W.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Infarction</u> <u>12:00</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arterio-sclerotic heart disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>hypertension, arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 2, 1936</u> to <u>May 4, 1956</u> , that I last saw the deceased alive on <u>May 3, 1936</u> , and that death occurred at <u>10:01 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. A. Knight</u>		DATE SIGNED <u>3066 - Grand Ave.</u>	
PHYSICIAN'S NAME (Type) <u>E. A. Knight</u>		<u>Working for R.E.</u>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial May 12, 1956</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town or county) (State) <u>Southland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Williams</u> ADDRESS <u>300-4 2nd St.</u>		24a. REC'D BY REGISTRAR DATE <u>5.10.56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Car. M. Talbot</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

*James M. H. ...
...*

RECEIVED

MAY 9 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05283

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>5238</u> <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> DOA c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P.G.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>7204 13th P. AVENUE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert William</u> <u>Harold</u> <u>Hoch</u>				4. DATE OF DEATH Month Day Year <u>May</u> <u>26</u> <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>8/18/51</u>		9. AGE (In years last birthday) <u>5</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>			
11. BIRTHPLACE (State or foreign country) <u>Amer</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer</u>					
13. FATHER'S NAME <u>Charles Hoch</u>				14. MOTHER'S MAIDEN NAME <u>Georgia Mae Hoch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>mother</u> <u>Takoma Park Police Dept.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thoracic hemorrhage</u> <u>419.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Bullet wound through chest</u> (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>shot self while playin' with pistol</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>6</u> m. <u>5/26</u> <u>1956</u> <u>7:45 P.M.</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
20f. (City or town) <u>Takoma Park P. G. Co. Md.</u>		20g. (County) <u>P. G.</u>					
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>5/26 /56</u>			
22a. BURIAL, CREMATION, or other disposal <u>Burial</u>		22b. DATE THEREOF <u>May 29, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Prince Georges Co. Md.</u>		22e. (State) <u>Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Hall</u>		ADDRESS <u>254 Carroll St.</u>		24a. REC'D BY REGISTRAR <u>5/26/56</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur Deod</u>		24c. REGISTRAR'S SIGNATURE <u>Arthur Deod</u>					

TO BE COMPLETED BY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only a preliminary examination is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 1

MAY 1955

RECEIVED
MAY 1955

5301

CERTIFICATE OF DEATH

05284
Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norbeck</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bradford Rest Home</u>		d. STREET ADDRESS <u>1 May</u>	
3. NAME OF DECEASED (Type or print) <u>Eliza</u> First <u>E.</u> Middle <u>Hopkins</u> Last		4. DATE OF DEATH <u>May 6</u> 19 <u>56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 26</u> 18 <u>62</u>
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Prestley Aukward</u>		14. MOTHER'S MAIDEN NAME <u>Lavinia Hill</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>Robert Hopkins</u>	
17. INFORMANT <u>Sandy Spring, Md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO <u>Cardiac incompetency</u> DUE TO <u>Hypertensive Cardiac Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinsonian Syndrome</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 10, 1950</u> , to <u>May 6, 1956</u> , that I last saw the deceased alive on <u>May 6, 1956</u> , and that death occurred at <u>10 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Webster Sewell</u> M.D.		ADDRESS (Street, city or town, state) <u>Norbeck Rd Silver Spring, Md</u>	
PHYSICIAN'S NAME (Type) <u>WEBSTER SEWELL</u>		DATE SIGNED <u>5-8-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>5/9/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Lunden</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR <u>5-6-56</u>		24b. REGISTRAR'S SIGNATURE <u>Katherine B. Lawler</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

MAY 14 1956

RECEIVED

05285

TO DECEASED MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further action is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FORWARD TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

3 A 1190107

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE		c. LENGTH OF STAY IN lb 34 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 120 Quincy Street		d. STREET ADDRESS 120 QUINCY STREET	
3. NAME OF DECEASED (Type or print) WILLIAM NONE HUGHES		4. DATE OF DEATH MAY 27 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 24, 1881
9. AGE (In years last birthday) 74 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRICKLAYER-CONTRACTOR		10b. KIND OF BUSINESS OR INDUSTRY BRICK-CONTRACTOR	
11. BIRTHPLACE (State or foreign country) WASHINGTON, DC		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS HUGHES		14. MOTHER'S MAIDEN NAME HARRIET MANDER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT SON-DONALD HUGHES		Address 120 QUINCY ST.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CIRCULARY ARTERY DISEASE DUE TO (c) UNDETERMINED		INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NONE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 27, 1956 , to May 27, 1956 , that I last saw the deceased alive on May 27, 1956 , and that death occurred at 11 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9600 OLD GEORGETOWN ROAD DATE SIGNED BETHESDA 14 MD.			
ACTUAL SIGNATURE Joseph L. Connor		M.D. 9600 OLD GEORGETOWN ROAD	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 5/31/56	
22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.		24a. REC'D BY REGISTRAR DATE 5-30-56	
24b. REGISTRAR'S SIGNATURE Bernice M. Thompson			

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director.

BUREAU K. S.

JUN 1 1961

RECEIVED
JUN 1 1961

5240

CERTIFICATE OF DEATH

05287-123

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>MD</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. LENGTH OF STAY IN 1b <u>14 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rock Hill Sanatorium</u>				d. STREET ADDRESS <u>Rock Hill Beach</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Elma</u> Middle <u>Elsie</u> Last <u>Hyland</u>				4. DATE OF DEATH Month <u>5</u> Day <u>28</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-19-1902</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Joseph Parks</u>				14. MOTHER'S MAIDEN NAME <u>Myrtus Landon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Abdington Sanatorium & Hospital</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tuberculous bronchopneumonia</u> DUE TO (b) <u>Chronic ulcerative tuberculosis, lung</u> DUE TO (c) <u>several yrs.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>14 May</u> , 19 <u>56</u> , to <u>28 May</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>28 May</u> , 19 <u>56</u> , and that death occurred at <u>12:30</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5100 Underwood St NW 5/28/56</u> DATE SIGNED <u>Wash DC</u>							
ACTUAL SIGNATURE <u>Chas H Wolcott</u>				PHYSICIAN'S NAME (Type) <u>Chas H Wolcott</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF <u>May 31/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Haven</u>	
22d. LOCATION (City, town, or county) <u>Green Haven Md</u>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm H Hume</u>				ADDRESS <u>Wm H Hume</u>		24a. REC'D BY REGISTRAR <u>G. Halson</u>	
24b. REGISTRAR'S SIGNATURE <u>G. Halson</u>				DATE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8 1 2000

9 NOV

17

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5303

CERTIFICATE OF DEATH

05288216
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. DISTRICT OF COLUMBIA COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Maryland				c. LENGTH OF STAY IN 1b 23 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
3. NAME OF DECEASED (Type or print) First Annie Middle Marie Last Johnson				4. DATE OF DEATH Month May Day 4 Year 56			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEP. DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 26, 1900	
9. AGE (In years last birthday) yrs. 55		IF UNDER 1 YEAR Months 5 Days 19 Hours 56		IF UNDER 24 HRS Hours 56 Min 56			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Household duties		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Robert Jackson				14. MOTHER'S MAIDEN NAME Catherine Marshall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. not available			
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Paroxysmal Atrial Flutter 141X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Carcinoma Lung DUE TO (c) Carcinoma of Tongue							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 11, 1956 , to May 4, 1956 , that I last saw the deceased alive on May 4, 1956 , and that death occurred at 1 P. M. from the causes and on the date stated above							
ACTUAL SIGNATURE TED CLEMENS, Jr. M.D.				ADDRESS (Street, city or town, state) The Clinical Center			
PHYSICIAN'S NAME (Type) TED CLEMENS, Jr.				DATE SIGNED The National Institutes of Health			
22a. BURIAL, CREMATION, OR REINTERMENT (Specify) Burial				22b. DATE THEREOF 5-8-56		22c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery	
22d. LOCATION (City, town, or county) Charles County				(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Montgomery Bros.				ADDRESS 913-Flaming, NW		24a. REC'D BY REGISTRAR DATE 16-56	
				24b. REGISTRAR'S SIGNATURE Bennie M. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED K. I.

MAY 20 1961

RECEIVED

5304
CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bradford Rest Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring	
		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Carrie Johnson First Middle Last		4. DATE OF DEATH Month May Day 18 Year 1956	
5. SEX femal	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1873
		9. AGE (In years last birthday) 82 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland.
13. FATHER'S NAME George Dorsey		14. MOTHER'S MAIDEN NAME Rachel Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
		17. INFORMANT Robert A. Johnson Address Sandy Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Hepatic and Colon DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 1953
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardiorenal D. Arthritis Herpes Zoster			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 9. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
		20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from July 26, 1936 , to May 18, 1956 , that I last saw the deceased alive on May 17, 1956 , and that death occurred at 7:50 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert L. Sewell M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) Webster Sewell, M.D. Norbeck Rt. 1 Silver Spring			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/21/56	22c. NAME OF CEMETERY OR CREMATORY Sandy Spring,	22d. LOCATION (City, town, or county) (State) Sandy Springs, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sewell		ADDRESS Rockville, Md.	24a. REC'D BY REGISTRAR DATE 5-23-56
		24b. REGISTRAR'S SIGNATURE Estimud B. Law	

TO REGISTER OR ATTEND: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 25 1956

2-13-26
RECEIVED
FBI

BUREAU V. A.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05290

Reg. Dist. No. 216

5305

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring B-2</u>			
f. STREET ADDRESS <u>Stewart Lane</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Francis Amanda Johnson</u>				4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-30-1894</u>	
9. AGE (in years last birthday) <u>61</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elmer Mathews</u>				14. MOTHER'S MAIDEN NAME <u>Lucinda Stewart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>EX-100-100000000</u> Address <u>Catharine Bedywist (daughter) same as this</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brosch</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Brosch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>5/5/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Good Hope</u>		22d. LOCATION (City, town, or county) (State) <u>Colesville, md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden - Rockville</u> ADDRESS <u>md</u>				24a. REC'D BY REGISTRAR <u>5-2-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bernie M. Thompson</u>	

MEDICAL CERTIFICATION

TO DECEASED: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, please attach to the certificate a statement, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MAY 9 1907

BUREAU

5306

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) District of Columbia COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 26 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1200 "0" Street, N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Thomasena Middle (none) Last Johnson		4. DATE OF DEATH Month May Day 20 , Year 19 56			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 23, 1905	
				9. AGE (In years last birthday) 50 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Household duties		11. BIRTHPLACE (State or foreign country) North Carolina	
						12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samson Peoples				14. MOTHER'S MAIDEN NAME Anneta Persons			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-40-2542		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of breast - metastatic 170x DUE TO to axillary lymph nodes, mediastinal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) lymph nodes DUE TO abdominal lymph nodes (c) and brain							INTERVAL BETWEEN ONSET AND DEATH months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from April 24 , 19 56 , to May 20 , 19 56 , that I last saw the deceased alive on May 20 , 19 56 , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Wm. M. Headley M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) William M. Headley, M.D.				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 5-21-56		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Ohio F. Allen ADDRESS 1200 9th Ave. N.W.				24a. REC'D BY REGISTRAR DATE 5-22-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be held by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5307

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SHARON CRONIC HOSP.</u>		d. STREET ADDRESS <u>7400 Bradley Blvd</u>	
3. NAME OF DECEASED (Type or print) First <u>Eleanor</u> Middle <u>Karsten</u> Last <u>Karsten</u>		4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 3, 1891</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Indianapolis Ind.</u>
12. CITIZEN OF WHAT COUNTRY? <u>American</u>		13. FATHER'S NAME <u>Charles E. Cox</u>	
14. MOTHER'S MAIDEN NAME <u>Emma Mason Cooley</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>##</u> (If yes, give war or date of service) <u>###</u>	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Mrs Karl Karsten</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> <u>4/22</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatoid arthritis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u> <u>17 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>April 9, 1935</u> to <u>May 7, 1956</u> , that I last saw the deceased alive on <u>April 28, 1956</u> , and that death occurred at <u>6:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Katharine A. Chapman</u> M.D.		ADDRESS (Street, city or town, state) <u>3934 Baltimore St.</u>	
PHYSICIAN'S NAME (Type) <u>KATHARINE ACHADMAN</u>		DATE SIGNED <u>May 7, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>May 7, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W. Barber</u>		ADDRESS <u>Daytonville, Ind.</u>	
24a. REC'D BY REGISTRAR <u>DATE 5-9-56</u>		24b. REGISTRAR'S SIGNATURE <u>Eustine B. Jowley</u>	

MEDICAL CERTIFICATION

TO HOST OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EUROPE V. S.

1871

1871

5398
CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Mont.</u>	
CITY (If outside corporate limits write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Olney</u>		<u>4 yrs</u>		TOWN <u>Olney</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>none</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Mary Ozella Kingla</u>				OF DEATH: <u>May 28 1956</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>		8. DATE OF BIRTH: <u>Sept 26, 1875</u>	
9. AGE last birthday: <u>80 yrs</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>at home</u>		10a. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Washington, DC, U.S.A.</u>	
13. FATHER'S NAME: <u>Levi Schneider</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Ozella Ellis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u>				16. SOCIAL SECURITY NO.: <u>no</u>			
17. INFORMANT & ADDRESS: <u>Mr. Louis R. Kingla</u>				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>Carcinoma of Colon</u>				<u>1 yr</u>			
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH, (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)		21c. WHERE DID (City or town) (County) (State)		21f. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>Dec</u> , 1955, to <u>May</u> , 1956, that I last saw the deceased alive on <u>May 27</u> , 1956, and that death occurred at <u>1:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>A.D. Bonifant</u>		M.D. <u>Sandy Spring Md</u>		DATE SIGNED <u>5/28/56</u>			
23. BURIAL, CREMATION REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 31/56</u>		NAME OF CEMETERY OR CREMATORY <u>Val Klawn</u>		LOCATION (City, town, or county) (State) <u>Rockville Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-28-56</u>		REGISTRAR'S SIGNATURE <u>Bertrude B Lawler</u>		24. FUNERAL DIRECTOR <u>Adams Funeral Home</u>		ADDRESS <u>4745 - 4th Ave - NW</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 1 1944

BUREAU OF

5309
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 134 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 4306 Tuckerman Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF (Type or print) First Malcolm Middle Henderson Last Kerr				4. DATE OF DEATH Month May Day 16 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 7, 1901	
9. AGE (In years last birthday) 54 yrs		IF UNDER 1 YEAR Months 5 Days 16 Hours 19 Min 56		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Professor		10b. KIND OF BUSINESS OR INDUSTRY University	
11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Charles M. Kerr		14. MOTHER'S MAIDEN NAME Annie Dodge	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 550-09-2173		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Insufficiency and Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Primary Generalized Amyloidosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that I attended the deceased from January 3, 1956 to May 16, 1956 that I last saw the deceased alive on May 16, 1956 and that death occurred at 1:15 P. M. from the causes and on the date stated above ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED May 16, 1956 ACTUAL SIGNATURE John T. Binion M.D. National Institutes of Health PHYSICIAN'S NAME (Type) John T. Binion, M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 18, 1956		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland				24. REC'D BY REGISTRAR DATE 1-1-56 REGISTRAR'S SIGNATURE Mary E. Farrelly			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director may detach for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

W. A. DUNN

1/10/50

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5310

CERTIFICATE OF DEATH

05295

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC.</u> b. COUNTY <u>...</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>...</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>...</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>William H. Hospital</u>				d. STREET ADDRESS <u>4126 Rock Creek</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Robert D. Starelf</u>				4. DATE OF DEATH <u>May 23 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 7 1900</u>		9. AGE (In years last birthday) <u>55</u> yrs.	10. IF UNDER 1 YEAR: Months <u>...</u> Days <u>...</u> Hours <u>...</u> Min. <u>...</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>...</u>				11b. KIND OF BUSINESS OR INDUSTRY <u>...</u>		11. BIRTHPLACE (State or foreign country) <u>...</u>	
12. CITIZEN OF WHAT COUNTRY? <u>...</u>							
13. FATHER'S NAME <u>Frank Kettler</u>				14. MOTHER'S MAIDEN NAME <u>Harriet Reichen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>...</u> (If yes, give war or dates of service) <u>...</u>				16. SOCIAL SECURITY NO. <u>...</u>		17. INFORMANT <u>...</u> Address <u>...</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Coronary Artery Thrombosis</u> DUE TO <u>Coronary Artery Sclerosis</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), (b), OR (c) <u>...</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>...</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>1 Mo.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>...</u> a. m. <u>...</u> p. m. <u>...</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>April 23, 1956</u> to <u>May 23, 1956</u> that I last saw the deceased alive on <u>May 21, 1956</u> , and that death occurred at <u>7:50 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert D. Starelf</u>				ADDRESS (Street, city or town, state) <u>5526 Neb. Ave. D.C.</u>			
PHYSICIAN'S NAME (Type) <u>Robert D. Starelf</u>				DATE SIGNED <u>5/22/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				22b. DATE THEREOF <u>5/24/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Washington, D.C.</u>				(State) <u>...</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u>				ADDRESS <u>2901 14th St. N.W.</u>		24a. REC'D BY REGISTRAR <u>...</u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>				DATE <u>5-24-56</u>			

MEDICAL CERTIFICATION

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 25 1956

BUREAU V. S.

5311

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Dist. of Col.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>2745-29th St., N.W.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Michael Kirby</u>		4. DATE OF DEATH Month Day Year <u>May 15 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 3, 1876</u>
9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>6 12</u>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael Kirby</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Flemming</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>006-10-4886</u>	
17. INFORMANT <u>John J. Kirby</u>		Address <u>Falls Church, Va. 609 Knollwood Dr.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio-Vascular-Renal System</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 5</u> , 19 <u>56</u> , to <u>May 15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 15</u> , 19 <u>56</u> , and that death occurred at <u>2:35 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Sidney C. Cousins</u> M.D. <u>3921 Longview St. N.W. 5/15/56</u> PHYSICIAN'S NAME (Type) <u>SIDNEY C. COUSINS</u> <u>Wash DC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-18-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>	24a. REC'D BY REGISTRAR <u>5-16-56</u> 24b. REGISTRAR'S SIGNATURE <u>Bennie M. H. Dean</u>

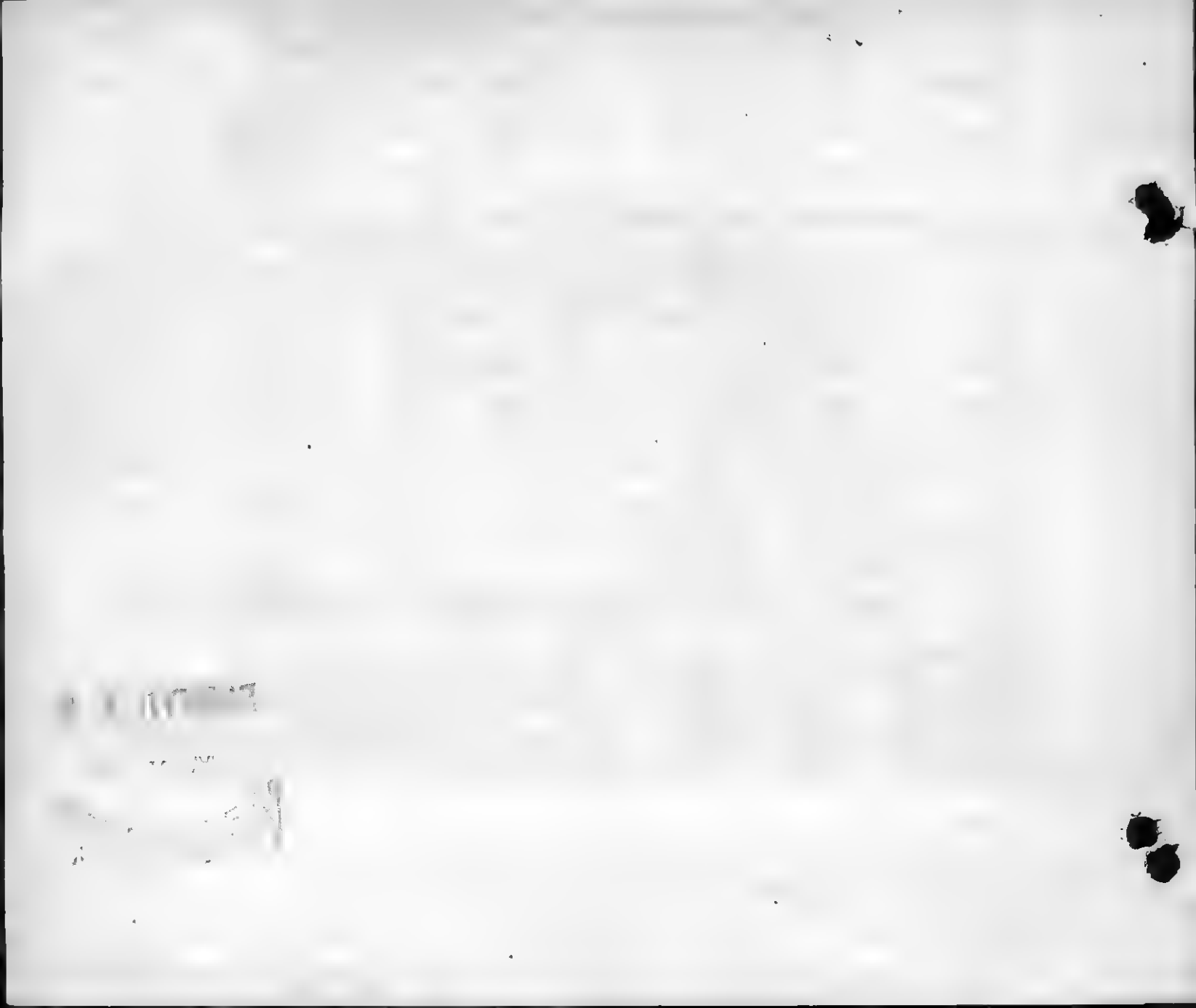
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

144

BUCKLE UP, B.

VS. AISME(S)
SM 9/55



5313

CERTIFICATE OF DEATH

05298

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 6 MO. 10 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SHARON CHRONIC HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
3. NAME OF DECEASED (Type or print) First SOPHIA Middle LOUISE Last KOHR		4. DATE OF DEATH Month MAY Day 17 Year 19 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 31, 1870
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SOCIAL SERVICE WORKER		10b. KIND OF BUSINESS OR INDUSTRY MANSFIELD, PENNSYLVANIA	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DANIEL DOTY		14. MOTHER'S MAIDEN NAME ESTER HOLLY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 579-12-5069D	
17. INFORMANT MR. H. G. BRUNK, 9916 Rogart Road		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia (Recurrent) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Week 1955 to May 17 1956 , that I last saw the deceased alive on May 13 1956 , and that death occurred at 11:25 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John N. Andrews		ADDRESS (Street, city or town, state) 9601 Cokesville Rd	
PHYSICIAN'S NAME (Type) John N. Andrews M.D.		DATE SIGNED May 17-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/21/56	
22c. NAME OF CEMETERY OR CREMATORY NATIONAL MEM. PARK CEMETERY		22d. LOCATION (City, town, or county) (State) FALLS CHURCH, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE 1956		24b. REGISTRAR'S SIGNATURE Gertrude B. Lawley	

MEDICAL CERTIFICATION

I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BRIDGE & CO.

1877

1877

5314

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Blaine</u>		c. LENGTH OF STAY IN 1b <u>15 min</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Monty Co. Gen. Hosp</u>			d. STREET ADDRESS <u>438 10th St. N.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Roger</u> Middle <u>Edgar</u> Last <u>Lancaster</u>			4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1952</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>est</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-27-1954</u>		9. AGE (in years last birthday) <u>2</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. DC.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Roger Lancaster</u>			14. MOTHER'S MAIDEN NAME <u>Pauline Prother</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Pauline Prother (mother) Same as item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhagic stroke of brain (pt posterior)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of skull 7-6-55</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>10 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Fell from porch at home to concrete basement</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>7-6</u> a. m. <u>1955</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Washington DC</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Frank J. Broschert</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>May 23 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brookgrove md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W Barber</u>		ADDRESS <u>Lyttonville md</u>		24a. REC'D BY REGISTRAR <u>5-28-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Katherine B Lawler</u>	

MEDICAL CERTIFICATION

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only a portion of the certificate is necessary, please execute the whole, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item 18. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. P.

JUN 1 1966

RECEIVED

5315

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 40 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. STREET ADDRESS 10516 Wheatley Street			
3. NAME OF DECEASED (Type or print) First Harvey Middle Holt Last Langley, Jr.				4. DATE OF DEATH Month May Day 15 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 31, 1946		9. AGE (In years last birthday) 9 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School boy			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Harvey Langley				14. MOTHER'S MAIDEN NAME Alta Riley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastric intestinal hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute lymphocytic leukemia DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DE. coli + Klebsiella septemia @ bronchopneumonia RLL RUL LLL							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 5 , 19 56 , to May 15 , 19 56 , that I last saw the deceased alive on May 15 , 19 56 , and that death occurred at 11:00A M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center May 15, 1956 National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE Arthur G. Ship, M. D.		NAME (Type) Arthur G. Ship, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Transit 5-17-56		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cem.		22d. LOCATION (City, town, or county) (State) Wilson County, No. Car.	
23. FUNERAL DIRECTOR'S SIGNATURE T. W. Cobb				ADDRESS Elm City, No. Car.		24a. REC'D BY REGISTRAR 5-16-56	
				24b. REGISTRAR'S SIGNATURE Bennie M. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 72 hours after death. Page 4 may be filled out by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATION

MAY 11 1961

RECEIVED

5316

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE West Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) South Charleston	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda, Md.				d. STREET ADDRESS 826 Jefferson Road		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gerald Middle Everett Last Lanier				4. DATE OF DEATH Month May Day 9 Year 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 3, 1946	
9. AGE (In years last birthday) 9 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Donald Lanier				14. MOTHER'S MAIDEN NAME Virginia Stover			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Possible intracerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute lymphocytic leukemia DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from May 8, 1956 , to May 9, 1956 , that I last saw the deceased alive on May 9, 1956 , and that death occurred at 9:05 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Martin Schick M.D.				ADDRESS (Street, city or town, state) The Clinical Center			
PHYSICIAN'S NAME (Type) Martin Schick, M. D.				DATE SIGNED 5/9/56 The National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial-Transit 5-12-56		5-12-56		Graceland Mem. Park.		Kanawha Co., West Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE H. D. Degan Degan Funeral Home				ADDRESS South Charleston, West Virginia.		24a. REC'D BY REGISTRAR 5-11-56	
				24b. REGISTRAR'S SIGNATURE Bernard Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AV 15 1000



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

531 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05302

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3611 Sheppard St</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> d. STREET ADDRESS <u>3611 Sheppard St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>Emmare Riggs Ledy</u>				4. DATE OF DEATH Month Day Year <u>May 1 1956</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 20, 1882</u>		9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR Months <u>3</u> Days <u>11</u> IF UNDER 24 HRS Hours <u>11</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>? Riggs</u>				14. MOTHER'S MAIDEN NAME <u>? Stacey</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>578-07-8179</u>		17. INFORMANT Address <u>Mrs J. Reynolds Smith, Sr. - Item# 2</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Cerebral occlusion</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>Frank J. Broschait</u> M.D. EXAMINER'S NAME (Type) <u>FRANK J. Broschait</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED <u>5-1-56</u>
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>5-4-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>			22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey-Bethesda, Md.</u>						24a. REC'D BY REGISTRAR DATE <u>5/3/56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		

TO DIE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only necessary, please execute and forward to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 2

W. E.

TO NO. 1 OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **CERTIFICATE OF DEATH**

053032 16

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY BETHESDA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN 1b <u>11 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CLINICAL CENTER, NIH</u>				d. STREET ADDRESS <u>5419 WHITLOCK ROAD</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALMA ELIZABETH LEE</u>				4. DATE OF DEATH Month Day Year <u>MAY 5 1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT 2, 1920</u>	
9. AGE (In years last birthday) yrs. <u>35</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>			
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>HARRY B. BLANCHARD</u>				14. MOTHER'S MAIDEN NAME <u>ALMA SWANN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>215-09-8514</u>			
17. INFORMANT <u>THE MEDICAL RECORD</u> Address <u>THE CLINICAL CENTER, BETHESDA 14 MARYLAND</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HODGKINS DISEASE</u> <u>901X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>APRIL 24</u> , 19 <u>56</u> , to <u>MAY 5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>MAY 5</u> , 19 <u>56</u> , and that death occurred at <u>7:40 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Martin Schick</u> M.D. <u>THE CLINICAL CENTER</u> <u>5/6/56</u> <u>THE NATIONAL INSTITUTES OF HEALTH</u> PHYSICIAN'S NAME (Type) <u>MARTIN SCHICK MD</u> <u>BETHESDA 14 MARYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 9, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry A. Witzke</u>				24a. REC'D BY REGISTRAR <u>MAY 8</u> DATE 24b. REGISTRAR'S SIGNATURE <u>Mrs. Bessie Thompson</u>			

S. A. DYNCE

1877

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5319

CERTIFICATE OF DEATH

053114

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <u>Montgomery</u> <u>MARYLAND</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda</u> LENGTH OF STAY (In this place) <u>25 days</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>D.C.</u> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington</u> 4100 STREET ADDRESS (If rural give location) <u>6135 30th St. N.W.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Katherine</u> <u>Mattern</u> <u>Lewis</u>				4. DATE (Month) (Day) (Year) <u>May</u> <u>9</u> <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb 9, 1876</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fitter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>		11. BIRTHPLACE (State or foreign country) <u>Wash.ington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter Mattern</u>				14. MOTHER'S MAIDEN NAME <u>Christine Dill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Christine Mattern - Sister</u> <u>6135 30th St, N.W. Wash.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>25 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Arteriosclerosis</u>						<u>5 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 1957</u> to <u>May 9, 1956</u> , that I last saw the deceased alive on <u>May 8, 1956</u> , and that death occurred at <u>5:20 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert M. Thompson</u>		M.D. <u>5516 Nebraska Ave D.C.</u>		DATE SIGNED <u>5-9-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/11/56</u>		NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
24. REC'D BY REGISTRAR DATE <u>5-10-56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>L.H. Hines</u> ADDRESS <u>2901 14th St NW Wash. D.C.</u>			

ELMER V. B.

MAY 14 1956

REGISTER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5320

CERTIFICATE OF DEATH

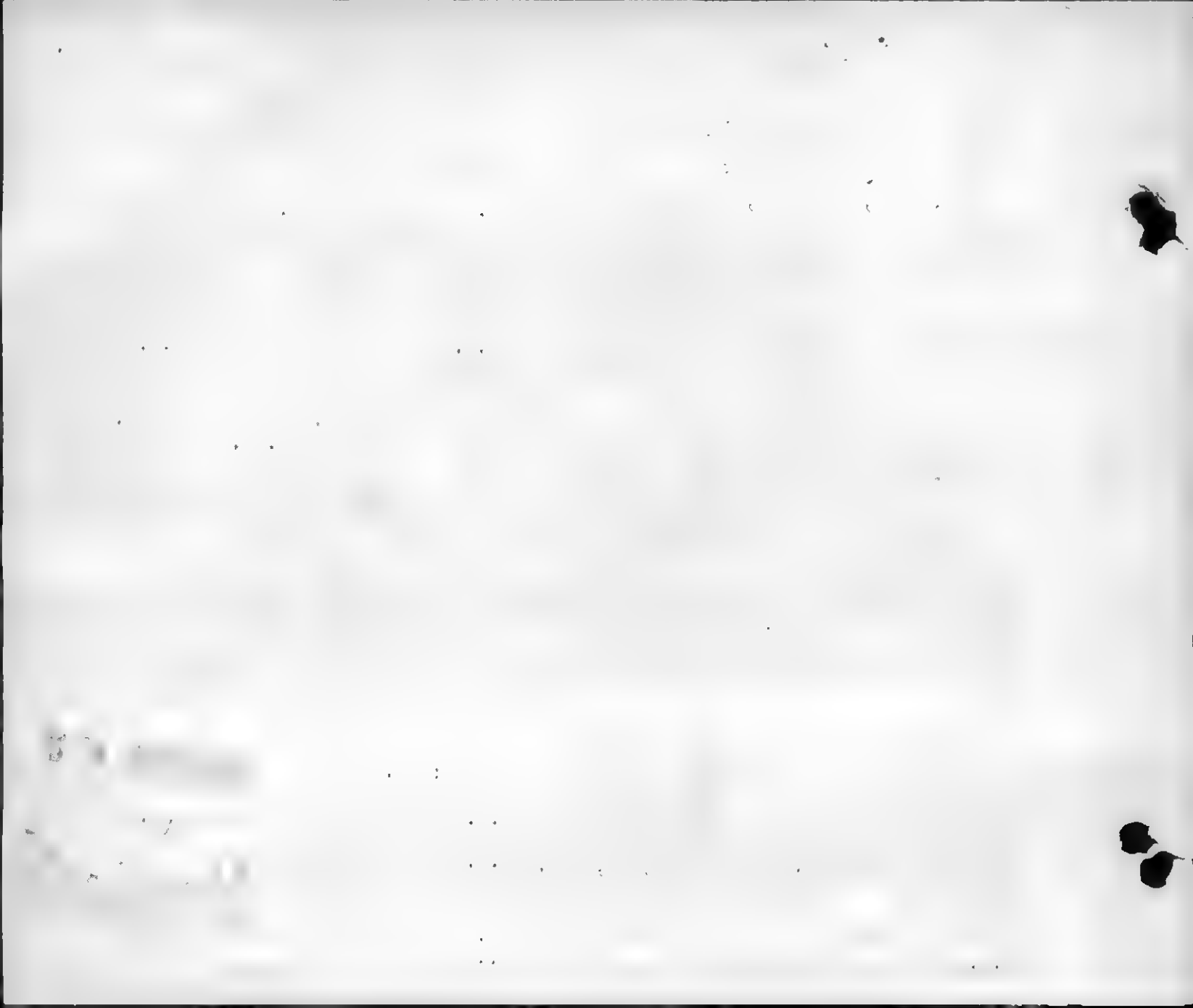
Reg. Dist. No.

05305

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution - Residence before admission) o STATE VIRGINIA b COUNTY ARLINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL BETHESDA				c. LENGTH OF STAY IN 1b 18 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USNH, NMMC, BETHESDA, MARYLAND				d. STREET ADDRESS 413 N. GEORGE MASON DR.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) CHARLES CLIFTON LOVENBERG				4. DATE OF DEATH MAY 15 1956			
5 SEX MALE	6. COLOR OR RACE CA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/26/26		9. AGE (In years last birthday) 29 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RESEARCH CHEMIST				10b. KIND OF BUSINESS OR INDUSTRY BUORD USN		11. BIRTHPLACE (State or foreign country) R.I.	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME CLIFTON LOVENBERG				14. MOTHER'S MAIDEN NAME FRANCES DARLING			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-II				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT 413 N. GEORGE MASON DR. ELNORA LOVENBERG ARLINGTON, VA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, lobular DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Leukemia, granulocytic, Acute DUE TO (c) Leukemia, granulocytic, Chronic						INTERVAL BETWEEN ONSET AND DEATH 2 days 2 1/2 wks 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 28 April 1956 to 15 May 1956 that I last saw the deceased alive on 15 May 1956 and that death occurred at 6:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Wm. B. Ingram M.D.				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 5-16-56			
PHYSICIAN'S NAME (Type) William B. Ingram, CDR, MC, USN. U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 21 May 1956		22c. NAME OF CEMETERY OR CREMATORY Swan Point Cemetery		22d. LOCATION (City, town, or county) (State) Providence, Rhode Island	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey R.A. Pumphrey Funeral Home, 7557 Wisconsin Ave.,				24a. REC'D BY REGISTRAR 4-16-56		24b. REGISTRAR'S SIGNATURE Wm. B. Ingram	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5321 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05306

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Dist. of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chevy Chase Club		d. STREET ADDRESS 2540 Mass. Ave. N.W. 308	
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-around; font-size: 1.2em;"> First THOMAS Middle HIXON Last LOWE </div>		4. DATE OF DEATH <div style="display: flex; justify-content: space-between;"> Month May Day 19 Year 19 56 </div>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-16-1879
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 10 Days 3	IF UNDER 24 HRS Hours 3 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Army Ret.		10b. KIND OF BUSINESS OR INDUSTRY Govt.	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William M. Lowe		14. MOTHER'S MAIDEN NAME Barbara C. Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> WW I & II		16. SOCIAL SECURITY NO. No	
17. INFORMANT Sarah I. Lowe, Wife		Address Above Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c) </div>			INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <div style="display: flex;"> <div style="margin-right: 10px;">Hour a. m. p. m.</div> <div>19</div> </div>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		DATE SIGNED 5-19-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-22-1956	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.	22d. LOCATION (City, town, or county) (State) Arlington Va.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda Md.	
24a. REC'D BY REGISTRAR DATE 5-21-56		24b. REGISTRAR'S SIGNATURE Bernie M. Thompson	

TO DO: MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any necessary, please enclose a copy of the death certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BOOKEND A. E.

5241

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 8 years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				d. STREET ADDRESS 804 Maplewood Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) 804 Maplewood Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MAY Middle LUCAS Last LUCAS				4. DATE OF DEATH Month May Day 10 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 7, 1873.	
9. AGE (In years last birthday) 82 yrs		IF UNDER 1 YEAR Months 10 Days 19 Hours 56 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY At home	
11. BIRTHPLACE (State or foreign country) Long Island, New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Rueben Arthur		14. MOTHER'S MAIDEN NAME Charlotte PAINE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. O. E. Mathiason, Calonia, New Jersey		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenitive Heart Failure DUE TO Coronary atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis with residual right hemiplegia DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from May 1, 1956 , to May 10, 1956 , that I last saw the deceased alive on May 10, 1956 , and that death occurred at 5:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 5/10/56							
ACTUAL SIGNATURE Charles H. Wolohon M.D.							
PHYSICIAN'S NAME (Type) Charles H. Wolohon				500 Underwood St. N. W. Washington, D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF May 12, 1956		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Wolohon				ADDRESS Takoma Park, DC.		24a. REC'D BY REGISTRAR 5/12/56	
24b. REGISTRAR'S SIGNATURE Charles H. Wolohon							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 14 1956

RECEIVED

CERTIFICATE OF DEATH

27/3

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C.		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 63 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington San. + Hosp.		d. STREET ADDRESS P.O. Box 7812 Ben Franklin Station		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles		First Louis		Middle Luedtke		Last	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 2, 1883	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 7 Days 2		IF UNDER 24 HRS. Hours 28 Min. 1956			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Foreign Serviceman		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (State or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Emily P. Cuergen		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO None		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal insufficiency DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 yr.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. n. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 28, 1956 , to May 28, 1957 , that I last saw the deceased alive on May 26, 1957 , and that death occurred at 9:40 A.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Wash. San + Hosp. Takoma Park		DATE SIGNED 5/19/57			
ACTUAL SIGNATURE J. W. Whitlock		M.D. Wash. San + Hosp. Takoma Park					
PHYSICIAN'S NAME (Type) J. W. WHITLOCK							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 5/28/56		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Southland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co.		ADDRESS 1400 Chapin St N.W.		24a. REC'D BY REGISTRAR 5/19/57		24b. REGISTRAR'S SIGNATURE John D. Dyer	

MEDICAL CERTIFICATION

FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

FOR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 21 1904

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5322
CERTIFICATE OF DEATH

05309

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>8607 Lancaster Drive</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Wilson Lyon</u>				4. DATE OF DEATH Month Day Year <u>May 5 1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-14-84</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. Govt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Oscar Lyon</u>				14. MOTHER'S MAIDEN NAME <u>M. Edna Hardenburg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Helene P. Lyon-Item# 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma - prostate or rectum</u> DUE TO (c) <u>10 yr</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 wk</u> <u>3 mo</u> <u>10 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1936</u> to <u>May 5, 1956</u> , that I last saw the deceased alive on <u>May 5, 1956</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>WIRTH POST RAKER</u> M.D. <u>1635 HAPVARD T NWASH DC</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>5/7/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE - 8-56</u>		24b. REGISTRAR'S SIGNATURE <u>Beau M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 17 1900

RECEIVED

5323

CERTIFICATE OF DEATH

05310

Reg. Dist. No. 21-6

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. LENGTH OF STAY in 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Nursing Home				e. STREET ADDRESS No. 1. Lawrence Court			
3. NAME OF DECEASED (Type or print) First RUTH Middle ALMA Last MCGUINNESS				4. DATE OF DEATH Month May Day 30 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Oct. 11, ?	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 57 Days 57 Hours 57 Min 57		IF UNDER 24 HRS Months 57 Days 57 Hours 57 Min 57		10. AGE (In years last birthday) 57 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Reg. Nurse				10b. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Unknown			
14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 018-12-6061				17. INFORMANT Ruth M. Aubrey, Daughter-Rockville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO (b) Arterio-sclerotic heart disease DUE TO (c) Hypertensive encephalopathy				INTERVAL BETWEEN ONSET AND DEATH 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral vascular accident				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Rockville				20g. (County) Montgomery		20h. (State) Md.	
21. I certify that I attended the deceased from June 5, 1955 to June 30, 1956 and that I last saw the deceased alive on June 30, 1956 and that death occurred at 9:30 P. M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 2600 ARKLAND DR Rockville Md.			
ACTUAL SIGNATURE Charles M. Weber M.D.				DATE SIGNED June 30, 1956			
PHYSICIAN'S NAME (Type) Charles M. Weber				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF 6-2-56				22c. NAME OF CEMETERY OR CREMATORY Parklawn Cem.		22d. LOCATION (City, town, or county) (State) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 5-8-56	
24b. REGISTRAR'S SIGNATURE Beattie M. Thompson							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

J. A. HENDERSON

25. 7

RECEIVED
JAN 10 1990

5324

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 136 SOUTHWOOD AVE.		d. STREET ADDRESS 136 SOUTHWOOD AVE.	
3. NAME OF DECEASED (Type or print) First JOHN Middle FLETCHER Last MERRICK		4. DATE OF DEATH Month MAY Day 22 Year 19 56	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 11, 1889
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONDUCTOR (Retired)		10b. KIND OF BUSINESS OR INDUSTRY PENNA. RAILROAD	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BENJAMIN F. MERRICK		14. MOTHER'S MAIDEN NAME MARGARET R. FLETCHER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 717-07-5882	
17. INFORMANT Mrs. Mary E. Merrick, 136 Wouthwood Ave. Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. with auricular Fibrillation (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Immediate 4 years 1 1/2 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from November 1954 , to May 22, 1956 , that I last saw the deceased alive on April 26, 1956 , and that death occurred at 7:10 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8801 Colesville Road, Silver Spring, Md. DATE SIGNED _____ ACTUAL SIGNATURE Russell B. Arnold M.D. PHYSICIAN'S NAME (Type) RUSSELL B. ARNOLD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/25/56	
22c. NAME OF CEMETERY OR CREMATORY EAST NEW MARKET CEMETERY		22d. LOCATION (City, town, or county) _____ (State) _____ EAST NEW MARKET, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Warner B. Humphrey		24a. REC'D BY REGISTRAR DATE 5/29/56	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Frances Tetter	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

S A JOURNAL

7 NOV 1957

14 March 1954

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5325
CERTIFICATE OF DEATH

05312

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Elizabeth Hospital</u>		d. STREET ADDRESS <u>2601 Ross Road</u>	
3. NAME OF DECEASED (Type or print) <u>Charles Webster Mifflin</u>		4. DATE OF DEATH <u>MAY 12 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 24 1885</u>
9. AGE (In years last birthday) <u>70</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Webster Mifflin</u>		14. MOTHER'S MAIDEN NAME <u>Rosalee Knolett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>17. INFORMANT</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA, TERMINAL</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMATOSIS, GENERALIZED</u> DUE TO (c) <u>CARCINOMA, PAPILLARY, BLADDER</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>4 MONTHS</u> <u>1 YEAR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROSIS, GENERALIZED</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>DEC. 24 1955</u> to <u>MAY 12 1956</u> , that I last saw the deceased alive on <u>MAY 11 1956</u> , and that death occurred at <u>8:10 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert G. Angle</u>		ADDRESS (Street, city or town, state) <u>5009 Del Ray Ave, Bethesda, Md</u>	
PHYSICIAN'S NAME (Type) <u>R obert G. Angle</u>		DATE SIGNED <u>5/12/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/15/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Family Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Owens, King Geo. Co., Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Peyer, Inc.</u>		ADDRESS <u>317 Pa. Ave. S. E. D.C.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Russie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained from the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 14 1956

BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05313

5326

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quince Orchard</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Gruthenberg R-3</u>				e. STREET ADDRESS <u>Gruthenberg R-3</u>			
3. NAME OF DECEASED (Type or print) First <u>Cilongo</u> Middle <u>Augustus</u> Last <u>Mitchell</u>				4. DATE OF DEATH Month <u>May</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-9-05</u>	
				9. AGE (in yrs. last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Peter Mitchell</u>				14. MOTHER'S MAIDEN NAME <u>Emma Imee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT <u>Ing Castile - Gruth. md R-3</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>48x Acute Cardiac failure</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Throat</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I. of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCART</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>5/31/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Seneca</u>	
				22d. LOCATION (City, town, or county) <u>Seneca, Md</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Surnden - Rockville, Md</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>5-31-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>William G. Locke</u>			

MEDICAL CERTIFICATION

TO DEPARTMENT OF HEALTH: This certificate should be submitted within 48 hours after death. If any other necessary, please enclose a copy of the death certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

5/11/1968

W. C. K.

11/11/68

5327

CERTIFICATE OF DEATH

Reg. Dist. No.

05314

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kenwood</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kenwood</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6816 Millwood Road</u>				d. STREET ADDRESS <u>6816 Millwood Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle <u>ELLA</u> Last <u>MITCHELL</u>				4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-27-1878</u>	
9. AGE (in years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>3</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Mitchell</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Holleman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Dr. James S. Dryden</u> Address <u>son-in-law Kenwood Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIO SCLEROSIS</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u> <u>10 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBRAL VASCULAR ACCIDENT</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
				20f. (City or town) <u></u>		(County) <u></u> (State) <u></u>	
21. I certify that I attended the deceased from <u>DECEMBER</u> 19 <u>55</u> , to <u>MAY 29</u> 19 <u>56</u> , that I last saw the deceased alive on <u>MAY 29</u> 19 <u>56</u> , and that death occurred at <u>2:15 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1835 Eye St. N.W. Washington D.C.</u> DATE SIGNED <u>May 30, 1956</u>							
ACTUAL SIGNATURE <u>Frederick W. Coe</u>				M.D. <u>1835 Eye St. N.W. Washington D.C.</u> <u>May 30, 1956</u>			
PHYSICIAN'S NAME (Type) <u>Frederick W. Coe</u>				<u>1835 Eye St. N.W. Washington, DC</u> <u>May 30</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-1-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Aulander Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Aulander No. Car.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey,</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 6-30-56</u>	
						24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be detached and filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A S.

NO. 1

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05315
217

5328

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. LENGTH OF STAY IN 1b <u>2 hrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montg Co. Gen. Hosp</u>				d. STREET ADDRESS <u>Ashton</u>			
3. NAME OF DECEASED (Type or print) <u>First</u> <u>Hoyt</u> <u>H.</u> <u>Morrison</u> <u>Morrison</u> <u>Last</u>				4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-17-22</u>	
9. AGE (In years to birthday) <u>34</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Tenn</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USC</u>							
13. FATHER'S NAME <u>E. M. Morrison</u>				14. MOTHER'S MAIDEN NAME <u>Laura Huntland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW #2</u>				16. SOCIAL SECURITY NO. <u>412-24-8247</u>		17. INFORMANT <u>Ruth Morrison (wife)</u> Address <u>same as decd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thoracic & Abdominal Hemorrhage</u> <u>25X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Internal Injuries</u> DUE TO (c) <u>A</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Comp fracture left leg</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>While driving of car which went out of control</u>			
20c. TIME OF INJURY Month, Day, Year <u>6:15</u> <u>5-12-56</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) <u>Chesley</u> (County) <u>Montg</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschait</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschait</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Shipment</u>		22b. DATE THEREOF <u>May 15, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sugar Creek Cemetery</u>		22d. LOCATION (City, town, or county) <u>Bradley County, Tennessee</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Humphrey</u> ADDRESS <u>Silver Spring, Md.</u>				24a. REC'D BY REGISTRAR <u>5/16/56</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Lewis</u>	

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, please execute and date, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



8/2/41

CERTIFICATE OF DEATH

05316

Reg. Dist. No. 211

5329

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Claggettville		c. LENGTH OF STAY IN 1b All Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Claggettville	
3. NAME OF DECEASED (Type or print) James A. Moxley		4. DATE OF DEATH Month May Day 20 Year 1956	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1 1876
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Washington Moxley		14. MOTHER'S MAIDEN NAME Sarah Baker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ##		16. SOCIAL SECURITY NO #####	
17. INFORMANT James E. Moxley		Address Mt. Airy Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adams-Stokes Syndrome DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO Hypertension		INTERVAL BETWEEN ONSET AND DEATH 2 mos. 10 years or more 20 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized osteoarthritis. Mild diabetes mellitus. Old cerebro-vascular accident. Benign prostatic hypertrophy		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. , 1955, to May 20 , 1956, that I last saw the deceased alive on May 20 , 1956, and that death occurred at 8:35 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Giloin F. Meadors, Jr.		M.D. Boyer Clinic, Damascus, Md. 5/22/56	
PHYSICIAN'S NAME (Type) Giloin F. Meadors, Jr. M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 23	
22c. NAME OF CEMETERY OR CREMATORY Montgomery Chapel		22d. LOCATION (City, town, or county) (State) Claggettville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber		24a. REC'D BY REGISTRAR Laytonsville Md.	
24b. REGISTRAR'S SIGNATURE Della V. Burdette		DATE May 23, 1956	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 25 1956

RECEIVED

5243

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>K. Ash Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Eugene Duke Mullin</u>		4. DATE OF DEATH <u>5</u> <u>31</u> <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/28/03</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sec. Dept of ag.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Secretary New York</u>	
11. BIRTHPLACE (State or foreign country) <u>Arner</u>		12. CITIZEN OF WHAT COUNTRY? <u>Arner</u>	
13. FATHER'S NAME <u>Eugene W. Mullin</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Duke</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>wife</u>		Address <u>8502 Greenwood Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Obstruction</u> DUE TO <u>162X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Primary Carcinoma of Bronchus</u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u> </u> Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that I attended the deceased from <u>May 6</u> , 1956, to <u>May 31</u> , 1956, that I last saw the deceased alive on <u>May 31</u> , 1956, and that death occurred at <u>10:55 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilford D. Meyers</u>		ADDRESS (Street, city or town, state) <u>8323 Radcliff Dr</u>	
PHYSICIAN'S NAME (Type) <u>WILFORD D. MEYERS</u>		DATE SIGNED <u>5-31-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 4-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City or town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Harkins</u>		ADDRESS <u>254 Carroll St</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>2</u>		1956	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2. After death, the attending physician or hospital official must sign the certificate and completely filled in by the funeral director. Pages 1 and 2 should be kept with the body until the body is buried or cremated. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the body until the body is buried or cremated, or removal, and in any event within 72 hours after death.

BOHND V. E.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be rec'd within 24 hours after death. The bottom may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 TOM

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5244

CERTIFICATE OF DEATH

05318

22,3

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>D.C.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Takoma Park</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Washington</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eventide Rest Home</u>				STREET ADDRESS <u>4825 48th Street, N.W.</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>KATHRYN</u> (First) <u>MURRAY</u> (Last)				4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>17th</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>3-18-85</u>	
9. AGE last birthday <u>71</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>business</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>business</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Reynolds</u>				14. MOTHER'S MAIDEN NAME <u>Susan Roach</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Coronary thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>				years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 20, 1946</u> to <u>May 6, 1956</u>, that I last saw the deceased alive on <u>May 6, 1956</u>, and that death occurred at <u>4:57</u> M. from the causes and on the date stated above.							
SIGNATURE <u>C.P. Ryland</u>				DATE SIGNED <u>5-7-56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>5/9/56</u>				NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		LOCATION (City, town, or county) (State) <u>Pr. Geo. Co., Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>J. William Doherty</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		ADDRESS <u>2901 14th St. N.W. Washington, D.C.</u>	

BUREAU V. E.

MAY 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5245

CERTIFICATE OF DEATH

05319
223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before adm ssion) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
c. LENGTH OF STAY IN 1b <u>15 days</u>				d. STREET ADDRESS <u>7105 Sycamore Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sun Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Pearl E (none) Myers</u>				4. DATE OF DEATH Month <u>May</u> Day <u>31</u> Year <u>1956</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>8-22-1898</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Geary Spicher</u>				14. MOTHER'S MAIDEN NAME <u>Tennie Polley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hosp Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Rhabdomyosarcoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>18 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5-15-56</u> to <u>5-31-56</u> , that I last saw the deceased alive on <u>5-30-56</u> , and that death occurred at <u>7:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul J. Starr</u> M.D.				ADDRESS (Street, city or town, state) <u>Takoma Park, Md.</u> DATE SIGNED <u>5-31-56</u>			
PHYSICIAN'S NAME (Type) <u>PAUL J. STARR</u>				- 11 Cornell Ave.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 2, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. [unclear]</u>				ADDRESS <u>254 Cornell St NW</u>		24a. REC'D BY REGISTRAR DATE <u>6/1/56</u>	
24b. REGISTRAR'S SIGNATURE <u>[unclear]</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 12 hours after death.

THE A. L. L. L. L.

1900

1900

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dis. **05320**

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> 5252 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN 1b <u>60 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Viivie Lane</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>Viivie Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>CLINTON T. NICHOLS</u> First Middle Last 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>10-5-1890</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE <u>65</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.			4. DATE OF DEATH <u>May 6 1956</u> Month Day Year 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>State Road</u> 11. BIRTHPLACE (State or foreign c.) <u>md</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>unknown</u> 14. MOTHER'S MAIDEN NAME <u>unknown</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Walter Nichols (son) James A. Shinn</u> Address			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>White Cardiac Failure</u> DUE TO (b) <u>10 years</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____			21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>. ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>Frank J. Broschart</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>5-6-56</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>5-9-56</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u> 22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Md.</u>			23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u> ADDRESS _____ 24a. REC'D BY REGISTRAR <u>5/14/56</u> 24b. REGISTRAR'S SIGNATURE <u>Laurel H. Hagler</u>		

MEDICAL CERTIFICATION

TO DEPT. OF HEALTH: This certificate should be executed within 24 hours after death. If any information is necessary, please enclose a copy of the death certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

EXPLAN V. S.

107

107

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

5330 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05321

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 3 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8708 Colesville Road -- Apt. 102				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 8708 Colesville Road - Apt. 102 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last ARTHUR THOMAS OGDEN				4. DATE OF DEATH Month Day Year May 16 19 56											
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 20, 1878		9. AGE (In years last birthday) 77 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant (retired)				10b. KIND OF BUSINESS OR INDUSTRY U. S. Government				11. BIRTHPLACE (State or foreign country) England				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Joseph Edward Ogden						14. MOTHER'S MAIDEN NAME Ann Unknown									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. ---				17. INFORMANT Address Mrs. Maurice N. Thompson, Silver Spring, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 450.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH sudden															
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
ACTUAL SIGNATURE <i>Frank J. Broschart</i> M.D. EXAMINER'S NAME (Type) Frank J. Broschart						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL						22b. DATE THEREOF 5/19/56		22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Werner & Humphrey</i>						ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 5/22/56		24b. REGISTRAR'S SIGNATURE <i>Francis Potter</i>					

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further information is necessary, please enclose a copy of this certificate with the body. Give pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 1

MAY 25 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5331

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05322

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			c. LENGTH OF STAY IN 1b 4 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1564 East-West Highway				d. STREET ADDRESS 1564 East-West Highway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EDWARD ALOYSIUS O'NEILL				4. DATE OF DEATH Month Day Year MAY 5 19 56			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 24, 1900		9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Co-ordinator of Service--Shoreham Hotel		10b. KIND OF BUSINESS OR INDUSTRY Brooklyn, New York		11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas A. O'Neill				14. MOTHER'S MAIDEN NAME Anna McGrath			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give war or dates of service) WW #2		16. SOCIAL SECURITY NO. 577-05-4414		17. INFORMANT Address Edward S. O'Neill, 1564 East-West Hgwy., SS., Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sudden DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Reptile bites							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. BROSCART		DATE SIGNED 5-5-56					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 8, 1956	22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Arlington County, Va.		22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Marion E. Pumphrey		ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR 5/8/56		24b. REGISTRAR'S SIGNATURE James H. Hatter	

MEDICAL CERTIFICATION

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, please execute in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Give Page 4 to the funeral director. Give Page 5 to the registrar. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAY 10 1900

RECEIVED

5332

CERTIFICATE OF DEATH

Reg. Dist. No.

05323

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Virginia b. COUNTY Alexandria	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 914 2nd Street	
3. NAME OF DECEASED (Type or print) First Janet Middle Marie Last PALMER		4. DATE OF DEATH Month May Day 11 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 July 1931
9. AGE (In years last birthday) 24 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Commercial	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Frank Gordon LAMBDIN		14. MOTHER'S MAIDEN NAME Mary E. DOTY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT James Albert PALMER (Husband) (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 92x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Bronchopneumonia DUE TO (c) Chronic Glomerulonephritis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH 16 min. 72 hours 4 years			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 20 April 1956 , to 11 May 1956 , that I last saw the deceased alive on 11 May 1956 , and that death occurred at 12:05 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Willard P. Arentzen, M.D. U.S. Naval Hospital, Bethesda, Md. 5-12-56			
ACTUAL SIGNATURE Willard P. Arentzen			
PHYSICIAN'S NAME (Type) Willard P. ARENTZEN, CDR, MC, USN. U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-14-56	
22c. NAME OF CEMETERY OR CREMATORY Southern Methodist Cemetery		22d. LOCATION (City, town, or county) (State) Alexandria, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE CUNNINGHAM Funeral Home, Cameron & Alfred Sts.		24a. REC'D BY REGISTRAR DATE 5-11-56	
24b. REGISTRAR'S SIGNATURE May E. Parrelly			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 14 1955

RECEIVED

CERTIFICATE OF DEATH

05324
Reg. Dist. No. 216

5333

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>2 mo. 10 days</u>		d. STREET ADDRESS <u>6413 Winnipeg Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lucille Ann</u> First Middle Last		4. DATE OF DEATH <u>May 19</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-23-1918</u>
9. AGE (In years last birthday) <u>37</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>9</u> <u>26</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Merrill, Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Martin Sebert</u>		14. MOTHER'S MAIDEN NAME <u>Randina Thronsen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Sister Mrs. Edward Cain</u> Address <u>5012 N. 64th St. Milwaukee, Wis.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Liver</u> DUE TO X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Adenocarcinoma of Colon</u> DUE TO (c) <u>6 Mo.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 29</u> , 19 <u>55</u> , to <u>date</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 19</u> , 19 <u>56</u> , and that death occurred at <u>7:10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Bethesda, Maryland</u> DATE SIGNED <u>—</u>			
ACTUAL SIGNATURE <u>John G. Ball</u>		PHYSICIAN'S NAME (Type) <u>John G. Ball</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit</u>		22b. DATE THEREOF <u>5-21-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wisconsin Memorial Pk.</u>		22d. LOCATION (City, town, or county) (State) <u>Milwaukee, Wisconsin</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>DATE 5-22-56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1911

1912



5334

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Dist. of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 18 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NNMC, Bethesda, Md.		e. STREET ADDRESS 5749 Southern St., S.E.	
3. NAME OF DECEASED (Type or print) First Hugh Middle Garmy Last PEARSON		4. DATE OF DEATH Month May Day 11 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 Feb. 1898
9. AGE (In years last birthday) 58 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draftsman		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	11. BIRTHPLACE (State or foreign country) Ireland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Hugh PEARSON	
14. MOTHER'S MAIDEN NAME Mary DOUGLAS		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO Unknown		17. INFORMANT (Wife) Mrs. Verna C. PEARSON (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic coma 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cirrhosis of the liver DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Esophageal varices			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 23 April 1956 , to 11 May 1956 , that I last saw the deceased alive on 11 May 1956 , and that death occurred at 9:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED William I. Freud M.D. U.S. Naval Hospital, NNMC, Bethesda, Md. 5/12/56			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) William I. Freud, LT, MC, USN U.S. Naval Hospital, NNMC, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 5-15-56	22c. NAME OF CEMETERY OR CREMATORY Wm Lee Crematory	22d. LOCATION (City, town, or county) (State) 4th & Mass. Ave., N.W. Wash. D.C.
23. FUNERAL DIRECTOR'S SIGNATURE LEE Funeral Home, 4th & Mass Ave., N.W. Wash, D.C.		24a. REC'D BY REGISTRAR DATE 5-11-56	24b. REGISTRAR'S SIGNATURE Mary E. Russell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 14 1953

RECEIVED

5335

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Dist. of Col.</u> b. COUNTY <u>47</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>5034 41st Street, N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Annie Margaret Perry</u>		4. DATE OF DEATH <u>May 15</u> 19 <u>56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1896</u>
9. AGE (In years last birthday) <u>59</u> yrs		IF UNDER 1 YEAR: Months <u>5</u> Days <u>9</u> Hours <u>5</u> Min <u>9</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Dist. of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George M. Stadtler</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Kirby</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Sister Marie Pyles, 5000 Saratoga Ave Bethesda</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Encephalomalacia, left cerebrum</u> DUE TO (b) <u>thrombosis left internal carotid</u> DUE TO (c) <u>5th day</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>4th</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 3</u> , 19 <u>56</u> , to <u>May 15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 14</u> , 19 <u>56</u> , and that death occurred at <u>0:25 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Washington, D.C.</u> DATE SIGNED <u>May 15, 1956</u>			
ACTUAL SIGNATURE <u>Sidney C. Cousins</u> M.D. <u>3921 Longwood N.W. 5/15/56</u>		PHYSICIAN'S NAME (Type) <u>SIDNEY C. COUSINS</u> <u>Wash 28</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-18-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>5-16-56</u> 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



— 100 —

CERTIFICATE OF DEATH

05327

Reg. Dist. No. 217

5336

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Va</u> b. COUNTY <u>Arlington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Columbian's Hospital</u>		d. STREET ADDRESS <u>2007 - Joyce St.</u>	
3. NAME OF DECEASED (Type or print) <u>Sophie</u> First <u>F.</u> Middle <u>PRICE</u> Last		4. DATE OF DEATH <u>May 23</u> 19 <u>56</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 2, 1894</u> 9. AGE (in years last birthday) <u>61</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Va</u>	
11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles A. Norton</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Martin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Albert J. Price</u> Address <u>2007 - Joyce St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart failure</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus, Fracture right femur (ununited) old injury</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 14</u> , 19 <u>56</u> , to <u>May 23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 20</u> , 19 <u>56</u> , and that death occurred at <u>10:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harry J. Kicherer</u> M.D. <u>2516 - Pa Ave SE</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>HARRY J. KICHERER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 26, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Croft Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. H. Lee-Sons C.</u> ADDRESS <u>300 - 4 St. N.E.</u>		24a. REC'D BY REGISTRAR <u>5-26-56</u>	24b. REGISTRAR'S SIGNATURE <u>Bernard B. Fowler</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. S.

1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5337 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05328

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN 1b _____ d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10543 St Paul st</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> d. STREET ADDRESS <u>10543 St Paul st</u> e. IS RES. DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Dorothy E Probey</u> First Middle Last			4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>1956</u>				
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-10-1911</u> 9. AGE (in years last birthday) <u>45</u> TH IF UNDER 1 YEAR: Months <u>4</u> Days <u>13</u> IF UNDER 24 HRS.: Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>P.H. Service</u> 11. BIRTHPLACE (State or foreign country) <u>Canada</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>? Mygrant</u>			14. MOTHER'S MAIDEN NAME <u>Chloe ?</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give war or dates of service) <u>Korean</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>J. F. Probey (husband)</u> Address <u>Dave as item 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year _____ Hour _____ a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) _____		20g. (County) _____		20h. (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Brosch</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>5-23-56</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22a. REC'D BY REGISTRAR <u>Bennie M. Thompson</u>			
22b. SUR AL. CREMATION, REMOVAL (Specify) <u>Burial</u>		22c. DATE THEREOF <u>5-26-56</u>		22d. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>			
22e. LOCATION (City, town, or county) <u>Montgomery</u>		22f. (State) <u>Maryland</u>		22g. REGISTRAR'S SIGNATURE _____			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				23a. ADDRESS <u>Bethesda, Md.</u>			

MEDICAL CERTIFICATION

TO DIE: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MAY 29 1956

BUREAU V. S.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G138-6-18-56-87

CERTIFICATE OF DEATH

Reg. Dist. No.

05329

216

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 4515 Avondale St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) CLINTON M. QUIGLEY				4. DATE OF DEATH Month May Day 30 , Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 14, 1901	
9. AGE (In years last birthday) 44 51 yrs.		IF UNDER 1 YEAR Months 7 Days 18		IF UNDER 24 HRS. Hours Min 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman				10b. KIND OF BUSINESS OR INDUSTRY Fighting Fires		11 BIRTHPLACE (State or foreign country) Pennsylvania	
12 CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME James C. Quigley				14. MOTHER'S MAIDEN NAME Mabel Hoffmaster			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Wife-Doris C. Quigley Address Bethesda, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic carcinoma 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) carcinoma of splenic flexure of colon DUE TO (c) 17 yrs.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12/2 , 19 54 , to 5/30 , 19 56 , that I last saw the deceased alive on 5/28 , 19 56 , and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6306 Wisconsin Ave. DATE SIGNED I. L. MARKS							
ACTUAL SIGNATURE I. L. MARKS				M.D. 6306 Wisconsin Ave.			
PHYSICIAN'S NAME (Type) I. L. MARKS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-2-1956		22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Md				24a. REC'D BY REGISTRAR 6-4-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOST OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 2 1950

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05330

Reg. Dist. No. 218

5339

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.F.D. #3</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Willie</u> First <u>Ridgley</u> Middle <u>Ridgley</u> Last			4. DATE OF DEATH <u>May</u> Month <u>22</u> Day <u>19</u> Year <u>56</u>				
5 SEX <u>male</u>		6. COLOR OR RACE <u>ore</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-14-1895</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labour</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Henry Ridgley</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Beel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Christine Ridgley (wife)</u> Address <u>Home as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. DATE OF CREMATION <u>5/26/56</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant View</u>		22d. LOCATION (City, town, or county) (State) <u>Quince Orchard, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Smucker</u> ADDRESS <u>Rockville, Md.</u>				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE <u>Shirley Cook</u>	

MEDICAL CERTIFICATION

TO DEPARTMENT OF HEALTH: This certificate should be executed within 24 hours after death. If any cause of death is necessary, please execute and forward, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 1 and 2 with the registrar prior to burial or cremation, or removal.

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CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall Rest Home				d. STREET ADDRESS 7001 Hillcrest Place			
3. NAME OF DECEASED (Type or print) ALBERT C. ROOT				4. DATE OF DEATH May 8, 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/19/65	
9. AGE (In years last birthday) 90		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Mail Service		11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank A. Root				14. MOTHER'S MAIDEN NAME Emma Clark			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Irving C. Root-Item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Block, complete, acute DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Generalised Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 30 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic prostatism with obstruction						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 1 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from July , 19 55 , to May 8 , 19 56 , that I last saw the deceased alive on May 8 , 19 56 , and that death occurred at 9:45 PM , from the causes and on the date stated above.							
REGISTRAR SIGNATURE Stewart Clapp				ADDRESS (Street, city or town, state) 3921 Ingoman St Wash DC			
REGISTRAR NAME (Type) Stewart Clapp				DATE SIGNED 5-8-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 5-9-56		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR 5-10-56		24b. REGISTRAR'S SIGNATURE Benjamin M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours of death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 14 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5341 CERTIFICATE OF DEATH

05332

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>117</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>139 das.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, NIH</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Samuel Felden Roth</u>		4. DATE OF DEATH Month Day Year <u>May 1 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1 May 1901</u>
9. AGE (In years last birthday) <u>55 yrs</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Theatre Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Motion Picture</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Morris Roth</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Felden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Not Avail.</u>	
17. INFORMANT <u>The Medical Record, Clinical Center, NIH</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive non-surgical fibrosarcoma</u> DUE TO <u>Pulmonary edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Moderate expansion of thorax + loose clot</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fatty metamorphosis liver</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 14, 1955</u> , to <u>May 1, 1956</u> , that I last saw the deceased alive on <u>May 1, 1956</u> , and that death occurred at <u>10⁵⁰ P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William M. Kramer</u> M.D.		ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>	
DATE SIGNED <u>5/2/56</u>			
PHYSICIAN'S NAME (Type) <u>William M. Kramer, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/4/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wash. Hebrew</u>		22d. LOCATION (City, town, or county) (State) <u>Congress Heights, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Kuryansky & Son D.W., Wash. D.C.</u>		ADDRESS <u>3501 14th St. N.W., Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>5-9-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

RECEIVED

NOV 11 1961

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05333**

5342				5342			
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4607 Maple Avenue				e. STREET ADDRESS 4607 Maple Avenue			
3. NAME OF DECEASED (Type or print) First Middle Last William A. ROYAL				4. DATE OF DEATH Month Day Year May 21 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 18, 1885	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days 19 3		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber				10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Johnson Co. N. Carolina	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William Royal				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 577-05-7656		17. INFORMANT Address Mrs. Viola Royal-Same Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion <div style="margin-top: 10px;"> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ </div> </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH sudden </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>				DATE SIGNED May 21, 1956			
EXAMINER'S NAME (Type) Frank J. Broschart, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-23-56		22c. NAME OF CEMETERY OR CREMATORY Parklawn		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 5-24-56		24b. REGISTRAR'S SIGNATURE <i>Bessie M. Linnifon</i>	

TO DEPARTMENT OF HEALTH: This certificate should be executed within 24 hours after death. If any necessary, please enclose a copy of the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 and 5 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
MAY 25 1956
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5343

CERTIFICATE OF DEATH

05334

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 33 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Gleenn Middle Christian Last Sager				4. DATE OF DEATH Month May Day 16 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 21, 1916		9. AGE (In years last birthday) yrs 39	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY U. S. Government		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Paul Christian Sager				14. MOTHER'S MAIDEN NAME Lydia Marie McFall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes - Active Serviceman		16. SOCIAL SECURITY NO Unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pulmonary congestion and hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) acute leukemia DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) liver abscess; gastrointestinal hemorrhage							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 13 , 19 56 , to May 16 , 19 56 , that I last saw the deceased alive on May 16 , 19 56 , and that death occurred at 10²³ P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Mehran Goulian M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland		DATE SIGNED 5/17/56	
PHYSICIAN'S NAME (Type) Mehran Goulian, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-17-56		22c. NAME OF CEMETERY OR CREMATORY WAGNER		22d. LOCATION (City, town, or county) (State) SD, DAKOTA	
23. FUNERAL DIRECTOR'S SIGNATURE Michael J. Rinaldi				ADDRESS 816-H St. NE		24a. REC'D BY REGISTRAR DATE 5-17-56	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

U.S. AIR FORCE

1956

100-100000-1

5246

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE <u>Maryland</u> b. COUNTY <u>Queens</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Vincent's Hospital</u>		d. STREET ADDRESS <u>1234 5th Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John S. Smith</u>		4. DATE OF DEATH Month Day Year <u>5 13 1956</u>	
5. SEX <u>Male</u> COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>6 17 89</u>	9. AGE (In years last birthday) <u>66</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Russia</u>
13. FATHER'S NAME <u>Samuel Shapiro</u>		14. MOTHER'S MAIDEN NAME <u>Hattie (L. Shapiro)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		17. INFORMANT <u>Mr. Jacob S. Smith</u> Address <u>St. Vincent's Hospital</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO <u>Coronary atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Diabetes mellitus</u> DUE TO <u>Diabetes mellitus</u> (c) <u>Diabetes mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10:15</u> , 19 <u>55</u> , to <u>5:13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5:13</u> , 19 <u>56</u> , and that death occurred at <u>5:10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John S. Smith</u> M.D.		ADDRESS (Street, city or town, state) <u>931 5th Ave. Queens, N.Y.</u>	
PHYSICIAN'S NAME (Type) <u>John S. Smith</u>		DATE SIGNED <u>5/16/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/15/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MONTEFIORE CEM</u>	22d. LOCATION (City, town, or county) (State) <u>QUEENS, N.Y.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Hare</u> ADDRESS <u>4217-9th Ave</u>		24. REC'D BY REGISTRAR <u>J. H. Hare</u> DATE <u>5/16/56</u>	
25. REGISTRAR'S SIGNATURE <u>J. H. Hare</u>		26. REGISTRAR'S SIGNATURE <u>J. H. Hare</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled out by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1c, 2, Film G192 June 21, 1956

CERTIFICATE OF DEATH

Reg. Dist. No.

05336

214

1 PLACE OF DEATH a COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a STATE District of Columbia b COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural KENSINGTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY in 1b 2 1/2 yrs.		d. STREET ADDRESS 1618 Hobart St. N.W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) EMMA First A. Middle SCHNEIDER Last		4. DATE OF DEATH Month May Day 31 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1861
9. AGE (In years last birthday) 95 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edwin F. Brooks		14. MOTHER'S MAIDEN NAME Emma Cooper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO	
17. INFORMANT Louis B. Schneider, Silver Spring, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio-sclerosis Heart Disease			
INTERVAL BETWEEN ONSET AND DEATH 3 months			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/1/56 , 19____, to 5/31/56 , 19____, that I last saw the deceased alive on 5/30/56 , 19____, and that death occurred at 7:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE James G. O'Keefe M.D.			
PHYSICIAN'S NAME (Type) James G. O'Keefe M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/2/56	
22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington D C	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Hankins		24a. REC'D BY REGISTRAR 6/2/56	
ADDRESS 756 Penna Ave N W Washington		24b. REGISTRAR'S SIGNATURE James P. Patten	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ANNALS

9 AM

7

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5247 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05337
7/13

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Takoma Park D.C.</u>				c. LENGTH OF STAY IN 1b <u>D.C.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u>			
3. NAME OF DECEASED (Type or print) <u>Peter Walter Scilemy</u>				d. STREET ADDRESS <u>249 Hawaii Ave, N.E</u>			
5. SEX <u>Male</u>				6. COLOR OR RACE <u>Wh.</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>5-29-30</u> <u>28</u> yrs.			
9. AGE (In years last birthday) <u>28</u> yrs.				10. DATE OF DEATH <u>5-12-1956</u>			
11. BIRTHPLACE (State or foreign country) <u>Johnstown Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Peter Scilemy</u>				14. MOTHER'S MAIDEN NAME <u>Mary Gluchman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>U.S. Army</u>				16. SOCIAL SECURITY NO. <u>254-12-1234</u>			
17. INFORMANT <u>Mrs. Margaret Scilemy - Wife</u>				Address <u>Johnstown Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause for line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial failure</u> DUE TO <u>Acute respiratory effort (Trumpet Play)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Myocardial Ischemia -</u></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Status thymicolymphaticus</u></p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>30 minutes</u></p> </div> </div>							
20a. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>5-13-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Shipment</u>				22b. DATE THEREOF <u>May 14, 1956</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Church Cemetery, Johnstown, Penna.</u>				22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Lumphrey</u>				ADDRESS <u>Silver Spring, Md.</u>			
24a. REC'D BY REGISTRAR <u>5/16/56</u>				24b. REGISTRAR'S SIGNATURE <u>J. Wilson Dadds</u>			

TO DEPARTMENT OF HEALTH: This certificate should be executed within 24 hours after death. If any information is necessary, please advise the State Health Department, Baltimore, Maryland, in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAY 16 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 215

5345

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY California	
c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Long Beach	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 835 Freeman Street • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lois Middle Ann Last SCRANTON		4. DATE OF DEATH Month May Day 8 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 January 1956
9. AGE (In years last birthday) yrs 3		IF UNDER 1 YEAR IF UNDER 24 HRS Months 8 Days 3 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Infant	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Buel SCRANTON		14. MOTHER'S MAIDEN NAME Isabelle Chaput	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) Buel SCRANTON (Same as #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Pulmonary Infarction 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) 3° burns 40% body, Rt. leg amputation DUE TO (c) due to gangrene, thrombophlebitis, legs INTERVAL BETWEEN ONSET AND DEATH 48 hours 18 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18). The infant was placed by the mother on a pillow, on a table, the burner was accidentally turned on and the child of	
20c. TIME OF INJURY Month, Day, Year Hour 0 p.m. Apr. 20 1956		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) St. Louis, Fort Campbell, Kentucky	
21. I certify that I attended the deceased from 2 May , 19 56 , to 8 May , 19 56 , that I last saw the deceased alive on 8 May , 19 56 , and that death occurred at 7:06 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 9 May 1956			
ACTUAL SIGNATURE Burt C. Johnson		M.D. U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) Burt C. Johnson, LCDR, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-9-56	22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Robert H. Humphrey		24a. REC'D BY REGISTRAR 5-8-56	
ADDRESS Bethesda, Md. R.A. Humphrey Funeral Home 7557 Wisc. Ave.,		24b. REGISTRAR'S SIGNATURE Mary E. Parrelly	

RECEIVED

MAY 10 1950

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 3, Film G196 5-10-56 et
5346
CERTIFICATE OF DEATH

05339
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 3 hr. 15 min.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 1117 Michigan Ave., N.E.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NMMC, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Anthony Last SEITZ		4. DATE OF DEATH Month May Day 6 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1986
9. AGE (In years last birthday) yrs 70		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes (If yes, give war or dates of service) WW-1		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mrs. Alida M. SEITZ, Wife, Same As #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction due to myocardial infarction DUE TO (c) Coronary thrombosis, at coronary artery		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 6 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 51 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5 May , 19 56 , to 6 May , 19 56 , that I last saw the deceased alive on 6 May , 19 56 , and that death occurred at 12:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 7 May 1956			
ACTUAL SIGNATURE Willard P. Arentzen M.D. U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) Willard P. Arentzen, CDR, MC, USN U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-9-56	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home		24a. REC'D BY REGISTRAR 5-7-56	
ADDRESS Washington, D.C.		24b. REGISTRAR'S SIGNATURE Mary E. Russell	

RECEIVED
MAY 9 1956
BUREAU V. 4

5347

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
c. LENGTH OF STAY IN 1b 2 days				d. STREET ADDRESS 1023 Girard St., N.E.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Frank		First Milton Middle SELLMAN Last		4. DATE OF DEATH Month May Day 5 Year 1956			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 20 May 1897	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 5 Days 19 Hours 56 Min		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME Frank SELLMAN (Deceased)		14. MOTHER'S MAIDEN NAME Lizzie WINSTON (Deceased)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) Yes <input checked="" type="checkbox"/> WW-1		16. SOCIAL SECURITY NO. WW-1		17. INFORMANT (Sister) Helen T. FORD (Sameas #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningitis 340.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumococcal pneumonia DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Urthral stricture				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3 May 1956 , to 5 May 1956 , that I last saw the deceased alive on 5 May 1956 , and that death occurred at 11:10 A.M. , from the causes and on the date stated above. Harold I. Passes, M.D. ADDRESS (Street, city or town, state) DATE SIGNED M.D. U.S. Naval Hospital, Bethesda, Md. 5-5-56							
ACTUAL SIGNATURE Harold I. PASSES, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-8-56		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Morrow & Woodford Funeral Home, 1622 11th St.,				ADDRESS Washington, D.C.		24a. REC'D BY REGISTRAR DATE 5-5-56	
				24b. REGISTRAR'S SIGNATURE Mary E. Tarsally			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 27 1956

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5348

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Rural		c. LENGTH OF STAY IN 1b 19 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. STREET ADDRESS 1004 10th Street	
3. NAME OF DECEASED (Type or print) First Ralph Middle Maurice Last SHEAF		4. DATE OF DEATH Month May Day 27 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-21-07
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR: Months 48 Days 48 Hours 48 Min. 48	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY Mariner Retired	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME William SHEAF		14. MOTHER'S MAIDEN NAME Louise TURNER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Wife Mrs. Hazel G. SHEAF		Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, esophagus DUE TO (b) 1004 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 3 mos			INTERVAL BETWEEN ONSET AND DEATH 3 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 8 May 19 56 Hour a. p. m. 1:20 P.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8 May 19 56 , to 27 May 19 56 , that I last saw the deceased alive on 27 May 19 56 , and that death occurred at 1:20 P. , from the causes and on the date stated above.			
ACTUAL SIGNATURE M. L. Gerber		ADDRESS (Street, city or town, state) USNH, NNMC, Bethesda, Maryland	
PHYSICIAN'S NAME (Type) M. L. GERBER, CAPT, MC, USN		DATE SIGNED 5-28-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-31-56	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Demaine Funeral Home		ADDRESS Alexandria, Va.	
24a. REC'D BY REGISTRAR DATE 5-28-56		24b. REGISTRAR'S SIGNATURE Mary E. Russell	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director may be notified. After this certificate has been signed by the attending physician and completely filled in, the funeral director may be notified. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

MAY 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5349

CERTIFICATE OF DEATH

05342

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 148 days		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION The Clinical Center, Bethesda, Md.		d. STREET ADDRESS 1835 Newton Street, N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Victoria Last Snowden		4. DATE OF DEATH Month May Day 10 Year 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1866	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR: Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Teaching school		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edward Snowden		14. MOTHER'S MAIDEN NAME Catherine Price	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, state or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation (bronchial obstruction) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malignant Melanoma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from December 14, 1955 , to May 10, 1956 , that I last saw the deceased alive on May 10, 1956 , and that death occurred at 11:30 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Claude E. Forkner, Jr. M.D.		ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED May 10, 1956	
PHYSICIAN'S NAME (Type) Claude E. Forkner, Jr., M.D.		The National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/12/56		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	
22d. LOCATION (City, town, or county) Washington, D.C.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		ADDRESS 2901 14th St. N.W.		24a. REC'D BY REGISTRAR Benie M. Thompson	
DATE 5-12-56					

BOULEVARD V. S.

"AY 15 1956"



5350 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: Mont. COUNTY <u>145-11 Colmanville Rd. Md.</u> CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Silver Springs Md.</u> HOSPITAL OR INSTITUTION OR MEET ADDRESS <u>Maxillea Tunney Home</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Springs Md.</u> STREET ADDRESS (If rural, give location) <u>145-11 Colmanville Rd.</u>	
3. NAME OF DECEASED: (Type or Print) <u>Mary A Stein</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>May 28 1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: <u>3/7/1862</u>
9. AGE last birthday <u>94</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country): <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Christian D. Mayer</u>		14. MOTHER'S MAIDEN NAME: <u>Katherine Betz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Gertrude Wannon</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE	(A) <u>Longestive heart failure</u>	<u>21</u>
ANTECEDENT CAUSE (B)	(B) <u>Arteriosclerosis vas. disc.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 1, 1956 to May 28, 1956, that I last saw the deceased alive on May 28, 1956, and that death occurred at 7:45 P.M. from the causes and on the date stated above.

SIGNATURE <u>[Signature]</u>	DATE SIGNED <u>May 28 1956</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>5/31/56</u>	NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>
DATE REC'D BY LOCAL REGISTRAR <u>5/29/56</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>
24. FUNERAL DIRECTOR <u>D. H. Hines Co.</u>	ADDRESS <u>2901-14th Ave.</u>

MARGIN RESERVED FOR BINDING

VS. A15—1023

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5351 CERTIFICATE OF DEATH

Reg. Dist. No. **05344**
296

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) o. STATE District of Columbia COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 17 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda, Md.				e. STREET ADDRESS 3121 "P" Street, N. W.			
3. NAME OF DECEASED (Type or print) First Susan Middle Margretta Last Stroup				4. DATE OF DEATH Month May Day 14 , Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1948	9. AGE (In years last birthday) 7 yrs.	IF UNDER 1 YEAR Months Days Hours Min	10. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Russell C. Stroup				14. MOTHER'S MAIDEN NAME Louise W. Wells			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock - Intestinal Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute lymphocytic leukemia DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 27, 1956 to May 14, 1956 , that I last saw the deceased alive on May 14, 1956 , and that death occurred at 12:25 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Martin Schick			M.D. The Clinical Center		DATE SIGNED May 14, 1956		
PHYSICIAN'S NAME (Type) Martin Schick, M.D.			ADDRESS (Street, city or town, state) National Institutes of Health Bethesda 14, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5/16/56		22c. NAME OF CEMETERY OR CREMATORY Spring Hill		22d. LOCATION (City, town, or county) (State) Lynchburg, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.				ADDRESS 2901 14th St. N.W. Washington, D. C.		24b. REGISTRAR'S SIGNATURE Beau M. Thompson	
				24a. REC'D BY REGISTRAR DATE 5-16-56			

BUREAU V. S.

MAY 22 1900

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5352

CERTIFICATE OF DEATH

05345

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>9 yrs</u>		d. STREET ADDRESS <u>9200 Burley Drive</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9200 Burley Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MAUD</u> Middle <u>M.</u> Last <u>SUTHERIN</u>		4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-20-1874</u>
9. AGE (in years last birthday) <u>82</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>0</u> Days <u>4</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David Morris</u>		14. MOTHER'S MAIDEN NAME <u>Susan Quinn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>--</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>John W. Sutherin-Husband</u>		Address <u>Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Endocardial thrombus</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 m.</u> <u>15 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 16</u> , 19 <u>56</u> , to <u>May 24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 24</u> , 19 <u>56</u> , and that death occurred at <u>8 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas L. Hartman</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>1834 Eye St. N.W., Wash. D.C.</u> <u>5/24/56</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS L. HARTMAN M.D.</u>		<u>1834 EYE ST. N.W., WASH. D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-26-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Montg. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda Md</u>	
24a. REC'D BY REGISTRAR <u>5-28-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bernie M. Thompson</u>	

TO HOST OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 29 1956

BUREAU V. S.

Reg. Dist. No.

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

5 21 5 27

14

17

VS A15 (4)
1 9/55

RECEIVED

MAY 14 1956

BUREAU V. E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5353
CERTIFICATE OF DEATH

Reg. Dist. No. 214

05348

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Kansas b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Maryland				c. LENGTH OF STAY IN 1b 6 days					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda, Md.				d. STREET ADDRESS none					
3. NAME OF DECEASED (Type or print) First Middle Last Myrtle Ethel Taylor				4. DATE OF DEATH Month Day Year May 31, 1956					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 14, 1887		9. AGE (In years last birthday) yrs. 69	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John A. Pierson				14. MOTHER'S MAIDEN NAME Frances Simmons					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bleeding esophageal varices DUE TO (c) Cirrhosis - Diabetes mellitus								INTERVAL BETWEEN ONSET AND DEATH Hours Days Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Myocardial infarction - Coronary heart disease								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)		20h. (State)			
21. I certify that I attended the deceased from May 25, 1956 to May 31, 1956 , that I last saw the deceased alive on May 31, 1956 , and that death occurred at 8:50 P.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE Daniel D. Federman M.D.				ADDRESS (Street, city or town, state) The Clinical Center The National Institutes of Health Bethesda 14, Maryland					
PHYSICIAN'S NAME (Type) Daniel D. Federman, M. D.				DATE SIGNED 6/1/56					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 6/1/56		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Independence Kansas			
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co				ADDRESS 1400 Chapin St		24a. REC'D BY REGISTRAR DATE 6/5/56			
				24b. REGISTRAR'S SIGNATURE Frances G. Geller					

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5253

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b One year	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 13019 Evanston St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NORA Middle R Last TETLOW		4. DATE OF DEATH Month May Day 8 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 10-1882
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR: Months 3 Days 28 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housework	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME C.O. McIntosh		14. MOTHER'S MAIDEN NAME Maria Moulden	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT M. Hough Daughter Item #2		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Atherosclerosis DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 1 day 20 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year May 19 Hour p. m. 		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I attended the deceased from May 1956 to May 1956 , that I last saw the deceased alive on May 1956 , and that death occurred at 9:44 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W.S. Murphy M.D. W.S. Murphy		DATE SIGNED May 1956	
PHYSICIAN'S NAME (Type) W.S. Murphy			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-10-56	22c. NAME OF CEMETERY OR CREMATORY Monocacy	22d. LOCATION (City, town, or county) Beallsville (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda Md	
24a. REC'D BY REGISTRAR DATE 5-11-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BLANK A 3

MAY 15 1950



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed with the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in (pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

5354

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

05350

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPRINGFIELD - BETHESDA	
c. LENGTH OF STAY IN 1b 39 DAYS		d. STREET ADDRESS 5407-CHRISTY DRIVE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ROS. MOR. 5721 GHOSVENOR LANE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Josephine Teresa Wall		4. DATE OF DEATH Month MAY Day 4 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 19, 1882
9. AGE (In years last birthday) 74 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) CANADA	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME PETER FOSTER	
14. MOTHER'S MAIDEN NAME BRIDGET SHREENAN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. —		17. INFORMANT THOMAS H WALL, JR. Address 5407 CHRISTY DRIVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of lung DUE TO (c) Generalized arteriosclerosis + myocardial degeneration		INTERVAL BETWEEN ONSET AND DEATH 12 hrs 1 yr 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/7 , 19 56 , to 5/4 , 19 56 that I last saw the deceased alive on 5/3 , 19 56 , and that death occurred at 3:55 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4301 48TH ST. NW., WASH. D.C. DATE SIGNED ACTUAL SIGNATURE S. A. Thomas M.D. 4301 48TH ST. NW., WASH. D.C. PHYSICIAN'S NAME (Type) S. A. Thomas 4301 48TH ST. NW., WASH. D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF MAY 7, 1956	22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY	22d. LOCATION (City, town, or county) (State) BUFFALO, NEW YORK
23. FUNERAL DIRECTOR'S SIGNATURE H. Hon. NEVOL		24a. REC'D BY REGISTRAR 5-7-56	
ADDRESS 2224-WIS. AVE. D.C.		24b. REGISTRAR'S SIGNATURE Bennie M. Thompson	

MEDICAL CERTIFICATION

RECEIVED

MAY 9 1950

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5355

CERTIFICATE OF DEATH

Reg. Dist. No.

05351
217

1 PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Blaine</u> <u>330 E. Diamond Ave.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montg. Co. Gaithersburg</u>		2 USUAL RESIDENCE (Where deceased lived If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Blaine Gaithersburg</u> d. STREET ADDRESS <u>330 E. Diamond Ave</u>									
3 NAME OF DECEASED (Type or print) <u>Mary E. Walton</u>		4 DATE OF DEATH Month <u>May</u> Day <u>31</u> Year <u>1956</u>									
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 12, 1876</u>								
9. AGE (In years last birthday) <u>79</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Maker</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> 11. BIRTHPLACE (State or foreign country) <u>England</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months	Days										
	Hours										
	Min										
13. FATHER'S NAME <u>Wm Walton</u>		14. MOTHER'S MAIDEN NAME <u>Jane Erwin</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Joseph Walton - Item #2</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart Failure.</u> DUE TO <u>Diabetic Coma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Diabetic Mellitus</u> DUE TO (c) <u>Diabetic Mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)								
21. I certify that I attended the deceased from <u>May 31, 1956</u> , to <u>July 31, 1956</u> , that I last saw the deceased alive on <u>July 31, 1956</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>Luciano L. Leal</u> M.D.		ADDRESS (Street, city or town, state) <u>108 N. Frederick Ave.</u> DATE SIGNED									
PHYSICIAN'S NAME (Type) <u>Luciano L. Leal</u>		<u>Gaithersburg Md.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>6-4-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>								
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md</u>	24a. REC'D BY REGISTRAR <u>5-31-56</u> 24b. REGISTRAR'S SIGNATURE <u>Kertrude B. Lawler</u>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 5 1956

U.S. DEPARTMENT OF AGRICULTURE

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 item 8, Baltimore
 5356 CERTIFICATE OF DEATH

05352211
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Woodfield				c. LENGTH OF STAY IN 1b 15 Years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Woodfield				d. STREET ADDRESS R.F.D. 1 Gaithersburg Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. 1 Gaithersburg Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LILLIAN GRIFFITH WARFIELD				4. DATE DEATH Month May Day 1 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 2 1872	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Own Farm Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles H. Griffith				14. MOTHER'S MAIDEN NAME Hester Dorsey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Miss. Mary C. Warfield, Gaithersburg, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic spastic colitis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 years 5 months							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 3 1956 to May 1 1956 ; that I last saw the deceased alive on April 30 1956 , and that death occurred at 10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Damascus, Md. DATE SIGNED 5/3/56 ACTUAL SIGNATURE James P. Kerr M.D. PRINTED NAME (Type) JAMES P. KERR M.D. Damascus Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 4 1956		22c. NAME OF CEMETERY OR CREMATORY Goshen Cent.		22d. LOCATION (City, town, or county) (State) Laytonsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Roy W. Barber				ADDRESS Laytonsville		24a. REC'D BY REGISTRAR DATE May 5 1956	
				24b. REGISTRAR'S SIGNATURE Della W. Burdette			

BUTLER V. S.

MAY 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached for use as the burial-transit permit. Pages 1 and 2 should be filled in by the funeral director, and completely filled in by the attending physician and completely filled in by the funeral director. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, Film 198 6-8-56 et

5357

CERTIFICATE OF DEATH

05353

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac-Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac-Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RFD#2 Rockville</u>		d. STREET ADDRESS <u>RFD#2 Rockville</u>	
3. NAME OF DECEASED (Type or print) <u>LOUISE</u> First <u>L.</u> Middle <u>WATKINS</u> Last		4. DATE OF DEATH <u>May 29,</u> 19 <u>56</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1879</u> <u>Feb. 29, 1959</u>
9. AGE (In years, last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR: Months <u>3</u> Days <u>3</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Stone</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Davidson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Russell C. Watkins- Item # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral anoxia</u> <u>DOUX</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Broncho-pneumonia</u> DUE TO (c) <u>Parkinsonism & generalized arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>3 days</u> <u>5 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/1/52</u> to <u>5/29/56</u> , that I last saw the deceased alive on <u>5/29/56</u> , and that death occurred at <u>1:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Pumphrey</u> M.D.		ADDRESS (Street, city or town, state) <u>Rockville Md</u>	
DATE SIGNED <u>5/31/56</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-2-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Browningsville Ch Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Browningsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 6/1/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Laurel Kragtorp</u>			

BUREAU V. 8

1906

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5358
CERTIFICATE OF DEATH

05354

Reg. Dist. No. 215

1. PLACE OF DEATH o COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NNMCM, Bethesda, Md.				d. STREET ADDRESS 1806 Wyoming Ave., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Oscar Middle Jabez Last WEEKS		4. DATE OF DEATH Month May Day 30 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 30 Sept. 1879		9. AGE (In years last birthday) yrs. 76	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Jabez WEEKS				14. MOTHER'S MAIDEN NAME Sarah DAVIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) WW-I & II		17. INFORMANT James E. WEEKS (Brother)		Address Swansboro, N.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Portal Vein thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the liver DUE TO (c) unknown.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Portal Cirrhosis						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 18 May , 19 56 , to 30 May , 19 56 , that I last saw the deceased alive on 30 May , 19 56 , and that death occurred at 11:35 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE William I. Freud M.D. U.S. Naval Hospital, Bethesda, Md. 5-31-56 PHYSICIAN'S NAME (Type) William I. Freud, LT, MC, USNR U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-4-56		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE S.H. HINES Funeral Home, 2901 14th St., N.W.				24a. REC'D BY REGISTRAR DATE 5-31-56		24b. REGISTRAR'S SIGNATURE Mary E. Russell	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STANDARD V. S.

1000
JUNE 1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5359 CERTIFICATE OF DEATH

05355

Reg. Dist. No. 211

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) p. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Germantown Md</u>				c. LENGTH OF STAY IN 1b <u>10 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cedar Grove Md</u>			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>OVIC H. WELLS</u>				4. DATE OF DEATH <u>MAY 28 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 13 1894</u>	
9. AGE (In years last birthday) <u>61 yrs</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming own</u>		11. BIRTHPLACE (State or foreign country) <u>Shedville Tenn</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>S. R. Wells</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Bowman</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>217367271</u>				17. INFORMANT <u>Hattie A Wells</u> Address <u>Germantown Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> <u>4:00.0</u> DUE TO <u>Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Chronic Arteriosclerosis</u> DUE TO <u>Heart Disease</u> (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>Jan 1956</u> , to <u>May 28, 1956</u> , that I last saw the deceased alive on <u>May 26, 1956</u> , and that death occurred at <u>8:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jack Schumacher</u> M.D.				ADDRESS (Street, city or town, state) <u>Smithsburg, Md</u> DATE SIGNED <u>5-29-56</u>			
PHYSICIAN'S NAME (Type) <u>Jack Schumacher</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
22b. DATE THEREOF <u>May 31 1956</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Salem</u>			
22d. LOCATION (City, town, or county) <u>Cedar Grove Md</u> (State) _____				23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W. Barbee</u> ADDRESS <u>Logtown Md</u>			
24a. REC'D BY REGISTRAR <u>Wella K. Burdette</u>				24b. REGISTRAR'S SIGNATURE <u>Wella K. Burdette</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 105356
5360 CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>MD.</u>	COUNTY <u>Mont.</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9401 Thornhill Dr.</u>		STREET ADDRESS (If rural give location) <u>9401 Thornhill Dr.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>HELEN</u>	(Middle) <u>WESTCOTT</u>	(Month) <u>May</u>	(Day) <u>20</u>
5. SEX <u>F</u> COLOR OR RACE <u>W</u>		6. AGE last birthday <u>81</u> yrs	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH <u>APRIL 14, 1874</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>AT HOME</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>JAMES HASKEL MOSES</u>		14. MOTHER'S MAIDEN NAME: <u>ELIZABETH FITCH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk): <u>2</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>1</u>	
17. INFORMANT'S ADDRESS: <u>HENRY H WESTCOTT, JR. 105356</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Mucoid carcinoma of the colon with metastases to the liver</u>		<u>1 year</u>	
ANTECEDENT CAUSE (B) <u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</u>			
(C) <u>Arteriosclerotic heart disease with decompensation</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION <u>October 15, 1955</u>	19B. MAJOR FINDINGS OF OPERATION <u>Mucoid carcinoma of ascending colon</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, etc.)	21C. WHERE DID INJURY OCCUR?	(County) (State)
21D. TIME (Month, (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 1955</u> , to <u>May 20, 1956</u> that I last saw the deceased alive on <u>May 12, 1956</u> , and that death occurred at <u>3:15 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Bennet A. Porter, M.D.</u>		DATE SIGNED <u>May 20, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. FUNERAL DIRECTOR <u>Joseph Daniels Sons, Wash. D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-24-56</u>		REGISTRAR'S SIGNATURE <u>Francis Hatter</u>	
NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>		LOCATION (City, town, or county) <u>Arlington, Virginia</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. B.

APR 1906

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5361
CERTIFICATE OF DEATH

05357
216

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) CHEVY CHASE				c. LENGTH OF STAY IN 1b 2 1/2 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6816 Brookville Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DOROTHY Middle WHITE Last WHITE				4. DATE OF DEATH Month MAY Day 5 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 9, 1895	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY		10b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT		11. BIRTHPLACE (State or foreign country) ROCHESTER, PA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME BERNARD WARTSKI				14. MOTHER'S MAIDEN NAME ROSA LISTANES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. ###		17. INFORMANT HARRY F. WHITE		Address 6816 BROOKVILLE ROAD, CHEVY CHASE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of uterus with extension to rectum DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) extension to rectum DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 8 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 2/13 , 19 57 , to 5/5 , 19 56 , that I last saw the deceased alive on 5/5 , 19 56 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Harold F. McCann M.D.				ADDRESS (Street, city or town, state) 3008 - 14th St. N.W. Washington, D.C.			
PHYSICIAN'S NAME (Type) HAROLD F. MCCANN				DATE SIGNED 5/5/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 8 1956		22c. NAME OF CEMETERY OR CREMATORY Laytonsville Cent.		22d. LOCATION (City, town, or county) (State) Laytonsville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Woy W. Barber				ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR 5-9-56	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR MAIL

NOV 17

RECEIVED
NOV 17 1944

TO HOSE OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

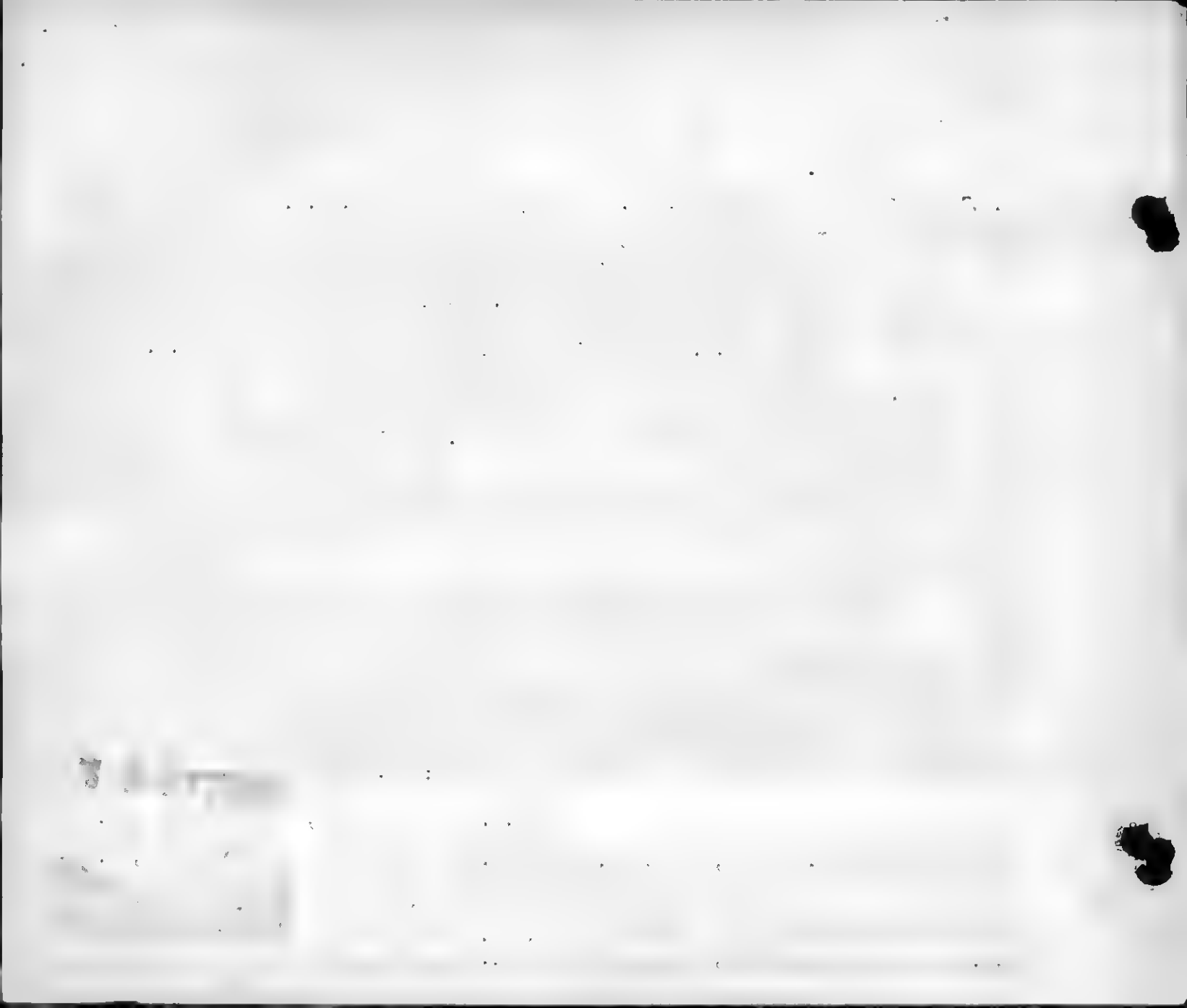
5362

CERTIFICATE OF DEATH

05358

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Columbia</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>		d. STREET ADDRESS <u>5901 31st Place, N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Otis</u> Middle <u>(n)</u> Last <u>WILDMAN</u>		4. DATE OF DEATH Month <u>May</u> Day <u>14</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 13, 1890</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy (Retired)</u>	
11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William A. WILDMAN</u>		14. MOTHER'S MAIDEN NAME <u>Kate KENDRICK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) <u>Yes</u> <u>WW-I & II</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>(Wife) Mrs. Carrie WILDMAN (Same As #2)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO <u>Coronary arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>9 hours</u> <u>15 years (approx)</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. p.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>14 May</u> , 19 <u>56</u> , to <u>14 May</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>14 May</u> , 19 <u>56</u> , and that death occurred at <u>10:43 P.M.</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>M.D. U.S. Naval Hospital, NMMC, Bethesda, Md.</u> DATE SIGNED <u>5-15-56</u>			
ACTUAL SIGNATURE <u>Bruce L. Canaga</u> PHYSICIAN'S NAME (Type) <u>Bruce L. CANAGA, CAPT, MC, USN</u> U.S. Naval Hospital, NMMC, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>17 May 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey</u> ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>May 15 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Bruce L. Canaga</u>		24c. REGISTRAR'S SIGNATURE <u>Bruce L. Canaga</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5363

CERTIFICATE OF DEATH

05359

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1232 - Noyes Drive</u>		d. STREET ADDRESS <u>1232 - Noyes Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Walter SUMNER Wilson</u>		4. DATE OF DEATH <u>May 15, 1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 25, 1892</u>
9. AGE (In years, last birthday) <u>64 yrs</u>		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN OF MACHINE OPERATORS PEP CO.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASHINGTON, D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES S. WILSON</u>		14. MOTHER'S MAIDEN NAME <u>CORA ECCLESTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW#1</u>		16. SOCIAL SECURITY NO. <u>577-05-0856</u>	
17. INFORMANT <u>MRS. GERTRUDE WILSON, 1232 NOYES DRIVE</u>		Address <u>SILVER SPRING, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>Acute Coronary Artery Thrombosis</u> DUE TO (c) <u>Coronary Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1948</u> to <u>May 15, 1956</u> , that I last saw the deceased alive on <u>May 14, 1956</u> , and that death occurred at <u>2:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James W. Long</u> M.D.		DATE SIGNED <u>9-15-1956</u>	
PHYSICIAN'S NAME (Type) <u>JAMES W. LONG</u>		ADDRESS (Street, city or town, state) <u>915 19th ST., N.W., WASHINGTON, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/17/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter C. Humphrey</u>		24a. REC'D BY REGISTRAR <u>5/22/56</u>	24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. A.

MAY 25 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5364 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05360

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		d. STREET ADDRESS <u>7127 Braeburn Place</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7127 Braeburn Place</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LEO</u> Middle <u>A2</u> Last <u>WOLFSOHN</u>				4. DATE OF DEATH Month <u>May</u> Day <u>24</u> , Year <u>19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 4, 1890</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>20</u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gov't. Emp.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Jacob M. Wolfsohn</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Bornstein</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. 		17. INFORMANT <u>Joel Wolfsohn - Item # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last, DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>5-25-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-27-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>National Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Falls Church Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u>				ADDRESS <u>Washington, D.C.</u>		24a. REC'D BY REGISTRAR <u>DATE 5-28-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>				24c. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the State Health Department, Baltimore, Maryland, for instructions. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

RECEIVED

MAY 29 1956

BUREAU V. S.

5365

CERTIFICATE OF DEATH

05361

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4522 Middleton Lane		d. STREET ADDRESS 4522 Middleton Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle Hall Last YOUNG		4. DATE OF DEATH Month May Day 13 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1874
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 11 Days 14 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Patent Attorney	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nicholas E. Young		14. MOTHER'S MAIDEN NAME Mary E. Cross	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) WWI <input checked="" type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Fanny Hempstone Young-Same Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertensive heart disease DUE TO (c) hypertension		INTERVAL BETWEEN ONSET AND DEATH 3 days 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September, 1953 , to 13 May , 19 56 , that I last saw the deceased alive on 13 May , 19 56 , and that death occurred at 4:55 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John M. Wyman M.D. 7659 Georgetown Road 14 May 56 Bethesda 14 Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/16/1956	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda		24a. REC'D BY REGISTRAR DATE 5-16-56	
24b. REGISTRAR'S SIGNATURE Beau M. Thompson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Y. S. Ito et al.

2000, 1999, 1998, 1997, 1996, 1995, 1994, 1993, 1992, 1991, 1990, 1989, 1988, 1987, 1986, 1985, 1984, 1983, 1982, 1981, 1980, 1979, 1978, 1977, 1976, 1975, 1974, 1973, 1972, 1971, 1970, 1969, 1968, 1967, 1966, 1965, 1964, 1963, 1962, 1961, 1960, 1959, 1958, 1957, 1956, 1955, 1954, 1953, 1952, 1951, 1950, 1949, 1948, 1947, 1946, 1945, 1944, 1943, 1942, 1941, 1940, 1939, 1938, 1937, 1936, 1935, 1934, 1933, 1932, 1931, 1930, 1929, 1928, 1927, 1926, 1925, 1924, 1923, 1922, 1921, 1920, 1919, 1918, 1917, 1916, 1915, 1914, 1913, 1912, 1911, 1910, 1909, 1908, 1907, 1906, 1905, 1904, 1903, 1902, 1901, 1900, 1899, 1898, 1897, 1896, 1895, 1894, 1893, 1892, 1891, 1890, 1889, 1888, 1887, 1886, 1885, 1884, 1883, 1882, 1881, 1880, 1879, 1878, 1877, 1876, 1875, 1874, 1873, 1872, 1871, 1870, 1869, 1868, 1867, 1866, 1865, 1864, 1863, 1862, 1861, 1860, 1859, 1858, 1857, 1856, 1855, 1854, 1853, 1852, 1851, 1850, 1849, 1848, 1847, 1846, 1845, 1844, 1843, 1842, 1841, 1840, 1839, 1838, 1837, 1836, 1835, 1834, 1833, 1832, 1831, 1830, 1829, 1828, 1827, 1826, 1825, 1824, 1823, 1822, 1821, 1820, 1819, 1818, 1817, 1816, 1815, 1814, 1813, 1812, 1811, 1810, 1809, 1808, 1807, 1806, 1805, 1804, 1803, 1802, 1801, 1800, 1799, 1798, 1797, 1796, 1795, 1794, 1793, 1792, 1791, 1790, 1789, 1788, 1787, 1786, 1785, 1784, 1783, 1782, 1781, 1780, 1779, 1778, 1777, 1776, 1775, 1774, 1773, 1772, 1771, 1770, 1769, 1768, 1767, 1766, 1765, 1764, 1763, 1762, 1761, 1760, 1759, 1758, 1757, 1756, 1755, 1754, 1753, 1752, 1751, 1750, 1749, 1748, 1747, 1746, 1745, 1744, 1743, 1742, 1741, 1740, 1739, 1738, 1737, 1736, 1735, 1734, 1733, 1732, 1731, 1730, 1729, 1728, 1727, 1726, 1725, 1724, 1723, 1722, 1721, 1720, 1719, 1718, 1717, 1716, 1715, 1714, 1713, 1712, 1711, 1710, 1709, 1708, 1707, 1706, 1705, 1704, 1703, 1702, 1701, 1700, 1699, 1698, 1697, 1696, 1695, 1694, 1693, 1692, 1691, 1690, 1689, 1688, 1687, 1686, 1685, 1684, 1683, 1682, 1681, 1680, 1679, 1678, 1677, 1676, 1675, 1674, 1673, 1672, 1671, 1670, 1669, 1668, 1667, 1666, 1665, 1664, 1663, 1662, 1661, 1660, 1659, 1658, 1657, 1656, 1655, 1654, 1653, 1652, 1651, 1650, 1649, 1648, 1647, 1646, 1645, 1644, 1643, 1642, 1641, 1640, 1639, 1638, 1637, 1636, 1635, 1634, 1633, 1632, 1631, 1630, 1629, 1628, 1627, 1626, 1625, 1624, 1623, 1622, 1621, 1620, 1619, 1618, 1617, 1616, 1615, 1614, 1613, 1612, 1611, 1610, 1609, 1608, 1607, 1606, 1605, 1604, 1603, 1602, 1601, 1600, 1599, 1598, 1597, 1596, 1595, 1594, 1593, 1592, 1591, 1590, 1589, 1588, 1587, 1586, 1585, 1584, 1583, 1582, 1581, 1580, 1579, 1578, 1577, 1576, 1575, 1574, 1573, 1572, 1571, 1570, 1569, 1568, 1567, 1566, 1565, 1564, 1563, 1562, 1561, 1560, 1559, 1558, 1557, 1556, 1555, 1554, 1553, 1552, 1551, 1550, 1549, 1548, 1547, 1546, 1545, 1544, 1543, 1542, 1541, 1540, 1539, 1538, 1537, 1536, 1535, 1534, 1533, 1532, 1531, 1530, 1529, 1528, 1527, 1526, 1525, 1524, 1523, 1522, 1521, 1520, 1519, 1518, 1517, 1516, 1515, 1514, 1513, 1512, 1511, 1510, 1509, 1508, 1507, 1506, 1505, 1504, 1503, 1502, 1501, 1500, 1499, 1498, 1497, 1496, 1495, 1494, 1493, 1492, 1491, 1490, 1489, 1488, 1487, 1486, 1485, 1484, 1483, 1482, 1481, 1480, 1479, 1478, 1477, 1476, 1475, 1474, 1473, 1472, 1471, 1470, 1469, 1468, 1467, 1466, 1465, 1464, 1463, 1462, 1461, 1460, 1459, 1458, 1457, 1456, 1455, 1454, 1453, 1452, 1451, 1450, 1449, 1448, 1447, 1446, 1445, 1444, 1443, 1442, 1441, 1440, 1439, 1438, 1437, 1436, 1435, 1434, 1433, 1432, 1431, 1430, 1429, 1428, 1427, 1426, 1425, 1424, 1423, 1422, 1421, 1420, 1419, 1418, 1417, 1416, 1415, 1414, 1413, 1412, 1411, 1410, 1409, 1408, 1407, 1406, 1405, 1404, 1403, 1402, 1401, 1400, 1399, 1398, 1397, 1396, 1395, 1394, 1393, 1392, 1391, 1390, 1389, 1388, 1387, 1386, 1385, 1384, 1383, 1382, 1381, 1380, 1379, 1378, 1377, 1376, 1375, 1374, 1373, 1372, 1371, 1370, 1369, 1368, 1367, 1366, 1365, 1364, 1363, 1362, 1361, 1360, 1359, 1358, 1357, 1356, 1355, 1354, 1353, 1352, 1351, 1350, 1349, 1348, 1347, 1346, 1345, 1344, 1343, 1342, 1341, 1340, 1339, 1338, 1337, 1336, 1335, 1334, 1333, 1332, 1331, 1330, 1329, 1328, 1327, 1326, 1325, 1324, 1323, 1322, 1321, 1320, 1319, 13

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VOLUME 96, PART 1

χ² = 0.000, df = 1, p = 0.999

F U L L . E N J O Y

$$= 0.75 \times 10^6 \times 1.5 \times 10^{-3} = 1.125 \times 10^3 \text{ N}$$

272

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[illegible]

BUREAU V. S.

MAY 21 1956

RECEIVED

REPORT V^e, 1876 T^r: V-VIII ann.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05362

5366

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Henrico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Richmond			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center National Institutes of Health Bethesda				e. STREET ADDRESS 2000 Southcliffe Road			
3. NAME OF DECEASED (Type or print) First Lee Middle Hammer Last Zirkle				4. DATE OF DEATH Month May Day 2 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 February 1910		9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles A. Hammer				14. MOTHER'S MAIDEN NAME Bertha Loewner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT The Medical Record, Clinical Center, NIH.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perforation of ascending colon & massive metastatic carcinoma of breast DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) g-3 hemorrhage DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 26-48 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) Richmond		(County) (State)	
21. I certify that I attended the deceased from July 5, 1955 , to May 2, 1956 , that I last saw the deceased alive on May 2, 1956 , and that death occurred at 12:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Arthur G. Ship				ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 5-2-56	
PHYSICIAN'S NAME (Type) Arthur G. Ship, M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 2, 1956		22c. NAME OF CEMETERY OR CREMATORY Richmond, Va		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Patterson				ADDRESS 3619-64 NW NW Washington DC		24a. REC'D BY REGISTRAR DATE 5/3/56	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

CERTIFICATE OF DEATH

BUREAU V. 3

MAY 7 1956

RECEIVED